Board of Health Meeting # 02-26

Public Health Sudbury & Districts

Thursday, February 19, 2026

1:30 p.m.

Boardroom

1300 Paris Street

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO subsections 49(3) and 51(1) of the *Health Protection and Promotion Act*, **Tom Trainor** of Lively be appointed as a part-time member of the Board of Health for the Sudbury and District Health Unit to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding three years, effective the date this Order in Council is made.

EN VERTU DES paragraphes 49 (3) et 51 (1) de la *Loi sur la protection et la promotion de la santé*, **Tom Trainor** de Lively est nommé au poste de membre à temps partiel du conseil de santé de la circonscription sanitaire de Sudbury et du district pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health
Recommandé par : La ministre de la Santé

Concurred: Chair of Cabinet
Appuyé par : La présidence du Conseil des ministres

Approved and Ordered: JAN 15 2026
Approuvé et décrété le :

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 40/2026

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – SECOND MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, FEBRUARY 19, 2026 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

- Lieutenant Governor appointment to the Board of Health for Public Health Sudbury & Districts, Tom Trainor, dated January 15, 2026

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) 2025 Year-In Review

- Stacey Laforest, Director, Health Protection Division
- Kathy Dokis, Director, Indigenous Public Health
- Stacey Gilbeau, Director, Health Promotion and Vaccine Preventable Diseases Division and Chief Nursing Officer
- M. Mustafa Hirji, Medical Officer of Health and Chief Executive Officer

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting – January 15, 2026

ii) Business Arising from Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health/Chief Executive Officer

a. MOH/CEO Report, February 2026

v) Correspondence

a. Highway Safety in Northern Ontario

- Letter from Northeastern Public Health Board of Health Chair to the Prime Minister and Premier of Ontario, dated January 14, 2026

b. Ministry Appointments – Public Health Sudbury & Districts Medical Officer of Health and Associate Medical Officer of Health

- Letter from the Deputy Premier and Minister of Health to the Board of Health Chair for Public Health Sudbury & Districts Re: Appointment of Dr. Mustafa Hirji, Medical Officer of Health dated February 5, 2026
- Letter from the Deputy Premier and Minister of Health to the Board of Health Chair for Public Health Sudbury & Districts Re: appointment of Dr. Emily Groot, Associate Medical Officer of Health dated February 5, 2026

vi) Items of Information

None

APPROVAL OF CONSENT AGENDA

MOTION:

THAT the Board of Health approve the consent agenda as distributed.

6. NEW BUSINESS

i) Follow-up to Inquiry on 2026–2028 Risk Management Plan Regarding High Risk Items with Minimal Mitigation from Controls

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated February 12, 2026

ii) Healthy Smiles Ontario Fee Schedule and the Impacts on Access to Dental Care for Children and Youth

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated February 12, 2026

HEALTHY SMILES ONTARIO FEE SCHEDULE AND THE IMPACTS IT HAS ON ACCESS TO DENTAL CARE FOR CHILDREN AND YOUTH

MOTION:

WHEREAS children and youth in Ontario face significant barriers in accessing dental care through the Healthy Smiles Ontario (HSO) program due to a fee-schedule that result in reduced provider participation; and

WHEREAS acceptance of HSO is at the discretion of individual dental providers, and many offices choose not to participate because reimbursement rates under the HSO Schedule of Dental Services and Fees are substantially lower than the 2025 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners; and

WHEREAS delayed or untreated dental issues can lead to pain, impaired concentration and school performance, disrupted eating and sleeping patterns, permanent tooth damage, the need for surgery under anesthesia, and in the most severe cases, life-threatening conditions; and

WHEREAS early prevention and detection significantly improve health outcomes and reduce strain on the healthcare system;

THEREFORE BE IT RESOLVED THAT the Board of Health requests that the Ministry of Health increase reimbursement rates outlined in the Healthy Smiles Ontario (HSO) Schedule of Dental Services and Fees for dentist providers, so that they align with the 2026 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners, in order to encourage provider participation in HSO and improve access to care for children and youth; and

FURTHER THAT the Board directs the Medical Officer of Health to engage in both cross-agency collaboration with other local public health agencies and agency-level advocacy to strengthen the case for improved HSO fee scheduling.

iii) Accountability Monitoring Plan Report

- 2025 Accountability Monitoring Plan Report

iv) New format for MOH/CEO Report to the Board

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated February 12, 2026

v) Constance Lake Inquest Jury Recommendations

- Letter and Verdict of Inquest Jury from the Office of the Chief Coroner, Ontario Forensic Pathology Service, Ministry of the Solicitor General, dated January 23, 2026

7. ADDENDUM

ADDENDUM

MOTION:

THAT this Board of Health deals with the items on the Addendum.

8. ANNOUNCEMENTS

9. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

Public Health
Santé publique
SUDBURY & DISTRICTS

MINUTES – FIRST MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, JANUARY 15, 2026 – 1:30 P.M.

BOARD MEMBERS PRESENT

Ryan Anderson
Robert Barclay
Michel Brabant
Renée Carrier
Abdullah Masood
Amy Mazey
Ken Noland
Michel Parent
Angela Recollet
Mark Signoretti

BOARD MEMBERS REGRET

Natalie Labbée
Natalie Tessier

STAFF MEMBERS PRESENT

Stacey Gilbeau
Emily Groot
Renée Higgins
M. Mustafa Hirji
Stacey Laforest
Chidubem Okechukwu, NOSM Resident
Rachel Quesnel, Recorder
Sarah Rice
Renée St Onge

R. QUESNEL PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:31 p.m.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

The agenda package was pre-circulated. R. Barclay disclosed a conflict of interest noting that a family member had applied for a position at Public Health Sudbury & Districts. This was acknowledged, and it was assessed that this conflict of interest would not be relevant to the items on today's agenda.

4. ELECTION OF OFFICERS

01-26 APPOINTMENT OF CHAIR OF THE BOARD

MOVED BY PARENT – RECOLETT: THAT the Board of Health appoints Mark Signoretti as Chair for the year 2026.

CARRIED

M. SIGNORETTI PRESIDING

02-26 APPOINTMENT OF VICE-CHAIR OF THE BOARD

MOVED BY BARCLAY – BRABANT: THAT the Board of Health appoints Mike Parent as Vice-Chair for the year 2026.

CARRIED

03-26 APPOINTMENT TO BOARD EXECUTIVE COMMITTEE

MOVED BY BARCLAY – CARRIER: THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2026:

1. **Michel Brabant, Board Member at Large**
2. **Angela Recollet, Board Member at Large**
3. **Ken Noland, Board Member at Large**
4. **Mark Signoretti, Chair**
5. **Michel Parent, Vice-chair**
6. **Medical Officer of Health/Chief Executive Officer**
7. **Director, Corporate Services**
8. **Secretary Board of Health**

CARRIED

04-26 APPOINTMENT TO FINANCE STANDING COMMITTEE OF THE BOARD

MOVED BY ANDERSON – RECOLLET: THAT the Board of Health appoints the following individuals to the Finance Standing Committee of the Board of Health for the year 2026:

1. **Natalie Tessier, Board Member at Large**
2. **Mike Parent, Board Member at Large**
3. **Renée Carrier, Board Member at Large**
4. **Mark Signoretti, Chair**
5. **Medical Officer of Health/Chief Executive Officer**
6. **Director, Corporate Services**
7. **Secretary Board of Health**

CARRIED

5. DELEGATION/PRESENTATION

i) Inquest into the deaths of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor

- Dr. Emily Groot, Acting Associate Medical Officer of Health, Public Health Sudbury & Districts

Dr. Emily Groot presented on the coroner's inquest into the 2021 blastomycosis outbreak affecting Constance Lake First Nation, which resulted in 40 infections and five deaths. The presentation reviewed the epidemiology of blastomycosis, Public Health's role in surveillance and education, and the purpose and process of coroner's inquests. The nine jury recommendations that are relevant to local public health were outlined, emphasizing commitments to Joyce's Principle, cultural safety, Indigenous engagement, support for Indigenous healing practices, improved access to public health programs, strengthened emergency preparedness, enhanced Indigenous representation in governance, and responsible Indigenous health data governance guided by OCAP® and data sovereignty principles. A supplementary document included in the today`s addendum package was prepared by the public health Indigenous Public Health team and outlines the nine recommendations to public health and what we are doing locally relating to the recommendations.

Questions and comments were entertained. Systemic challenges such as delayed diagnosis, jurisdictional gaps, and the need for culturally safe healthcare were highlighted. The Board noted the importance of actionable strategies, resource allocation, clinician engagement and addressing systemic racism. The board acknowledged these concerns, opportunities to learn from the recommendations, and recognized the necessity for ongoing improvements and Indigenous representation in public health leadership.

In response to an inquiry, additional information will be shared with M. Parent regarding overall provincial blastomycosis data and historical data. E. Groot was thanked for the presentation.

6. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Eight Meeting – November 20, 2025

ii) Business Arising from Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health/Chief Executive Officer

a. MOH/CEO Report, January 2026

v) Correspondence

a. Draft Revised Ontario Public Health Standards and Protocols

- Memorandum from Dr. K. Moore, Chief Medical Officer of Health and Assistant Deputy Minister, dated December 9, 2025

b. National Data on Substance-Related Harms

- Statement from the Council of Chief Medical Officers of Health dated December 11, 2025

c. Monitoring Food Affordability and Implications for Public Policy and Action

- Memorandum from the Middlesex-London Health Unit Medical Officer of Health and Board of Health Chair dated December 11, 2025
- Infographic: Food Insecurity, Middlesex-London 2026

d. Adverse Childhood Experiences (ACEs) Local Policy Advancement

- Report from Windsor-Essex County Health Unit Board of Health dated November 20, 2025

e. Prevention and Response to Radon Exposures in Windsor-Essex County

- Report from Windsor-Essex County Health Unit Board of Health dated November 20, 2025

f. Windsor and Essex County School Food Programs

- Report from Windsor-Essex County Health Unit Board of Health dated November 20, 2025

g. Indigenous Membership on Boards of Health

- Letter from the alPHa Board of Directors Chair to the Deputy Premier and Minister of Health dated November 10, 2025

vi) Items of Information

a. Annual Survey Results from 2025 Regular Board of Health Meeting Evaluations

b. Annual Meeting Attendance Summary Board of Health for Public Health Sudbury & Districts 2025

Various questions were entertained regarding the Board report and items of correspondence. R. Barclay shared his interest in participating in the alPHa Winter Symposium.

05-26 APPROVAL OF CONSENT AGENDA

MOVED BY MAZEY – MASOOD: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

7. NEW BUSINESS

i) Risk Management Plan 2026 – 2028

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 8, 2026
- Inherent and Residual Risk Ratings
- 2026 – 2028 Risk Management Plan

M.M. Hirji noted that risk management is a good governance practice and is an organizational requirement under the Ontario Public Health Standards. Risk management helps the organization achieve better outcomes by guiding how we handle threats that could disrupt operations and highlights strategic opportunities.

The current risk management process has been in place since 2016 and modeled after what is used by Treasury Board Secretariat. The 2026–2028 Risk Management Plan reports two risk levels including inherent (status quo) and residual (what is anticipated risk once identified controls are implemented). The Board of Health will receive updates on the monitoring of how the controls are moving the risk rating from inherent risk rating to residual risk rating through the annual risk report.

The Board was asked to approve the 2026–2028 Risk Management Plan, which will be phased in over three years and includes several controls with financial impacts. While many controls can begin immediately, the plan is designed to guide future investment decisions by prioritizing critical controls that most effectively reduce risk. Critical controls have been identified where controls will mitigate more than one risk. A summary table highlights these priority controls, many of which currently address risks in the high-risk category; the aim is to move these risks to moderate or lower levels, where possible. While health issues are worsening and more complex, we are not seeing this reflected in provincial funding and financial constraints impact the ability to implement all controls immediately. The risk management tool will support provincial reporting and help inform the need for enhanced public health funding.

Questions were entertained. The Board shared concerns regarding six red zone inherent risks that, with implemented controls, will remain red residual risks. M.M. Hirji explained that given the nature of these risks being outside of the control of Public Health Sudbury & Districts coupled with inadequate funding, we cannot realistically mitigate these risks to a lower risk category; however, we will continue to advocate for public health funding and for concerted action by provincial and federal partners. Based on a request by some board members for more information on these six risks, M.M. Hirji will bring a briefing note to the next Board meeting to provide more detail on these six risks and what would be needed to mitigate them to a lower risk category.

It was suggested that M.M. Hirji inquire with public health peers whether they have risk controls that might help inform our plan. M.M. Hirji explained that this was already done in preparation of the Risk Management Plan.

06-26 RISK MANAGEMENT PLAN 2026 - 2028

MOVED BY BRABANT - NOLAND: WHEREAS effectively planning to manage risks enables an organization to better achieve its outcomes, operate strategically, and be resilient to changing circumstances; and

WHEREAS the Ontario Public Health Organizational Requirements mandate boards of health to provide governance direction and oversight of risk management with a formal risk management framework that identifies, assesses, addresses risks; and

WHEREAS the Board of Health has engaged in a risk management process in order to systematically identify/assess current risks and controls;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts approve the 2026-2028 risk management plan.

CARRIED

ii) Ontario Building Code – Amendment to the Fee Schedule for Services Under Part VIII

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 8, 2026
- Revised Board of Health Manual G-I-50 – By-law 01-98

Under the Ontario *Building Code Act* Part VIII, Public Health Sudbury & Districts is designated as the enforcement authority for private onsite sewage systems which are typically in place when municipal sewage services are unavailable. To continue to administer the Part VIII program on a cost-recovery basis in 2026, it is necessary for Public Health Sudbury & Districts to amend program user fees in accordance with the rate of inflation. It was recapped that, last year, the Board of Health approved a new review process for an annual expedited review and adjustment of fees to inflation, with a more comprehensive review to occur every five years.

Today's proposed increase adjusts the fees by 2% to address increasing program operation and delivery costs. Per the *Building* Code requirements, notifications and a public meeting was held with no concerns having been reported.

07-26 AMENDMENT TO THE FEE SCHEDULE FOR SERVICES UNDER PART VIII OF THE ONTARIO BUILDING CODE

MOVED BY RECOLLET – ANDERSON: WHEREAS the Board of Health is mandated under the *Ontario Building Code Act* (S.O. 1992 c. 23), to enforce the provisions of this Act and the Building Code related to sewage systems; and

WHEREAS program related costs are funded through user fees on a cost-recovery basis; and

WHEREAS the proposed fees are necessary to address current program associated operational and delivery costs; and

WHEREAS the Board of Health has adopted a process of annually adjusting fees in accordance with inflation with a comprehensive review of fees conducted every five years; and

WHERAS fees have been proposed to increase in accordance with inflation for this annual adjustment; and

WHEREAS in accordance with Building Code requirements, staff have held a public meeting and notified all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases, with no concerns having been reported;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the amendments in Part VIII-Ontario Building Code fees as outlined within Schedule "A" to Board of Health By-law 01-98.

CARRIED

iii) Board of Health Meeting Date

Municipal elections in Ontario will be held on October 26, 2026, and the terms of municipal appointees on Boards of Health will end on November 14, 2026. It is anticipated that municipal appointments to our Board of Health will not be completed by the Board meeting of November 19, 2026 (third Thursday of the month) thereby risking quorum and a new Board who has to consider the budget without proper orientation; therefore, it is recommended that the November Board meeting date be moved to November 12, 2026.

08-26 CHANGE IN BOARD OF HEALTH MEETING DATE

MOVED BY CARRIER - MAZEY: WHEREAS the Board of Health regularly meets on the third Thursday of the month; and

WHEREAS By-Law 04-88 in the Board of Health Manual stipulates that the Board may, by resolution, alter the time, day or place of any meeting;

WHEREAS the *Municipal Election Act* section 6(1) provides that terms of municipal elected officials end on November 14, 2026, and so municipal appointments to the Board of Health expire on November 14, 2026;

WHEREAS it is desirable to ensure continuity and quorum for the November 2026 Board of Health meeting;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the regular Board of Health meeting scheduled for 1:30 pm Thursday, November 19, 2026, be moved to 1:30 pm on Thursday, November 12, 2026.

CARRIED

8. ADDENDUM

09-26 ADDENDUM

MOVED BY BRABANT - BARCLAY: THAT this Board of Health deals with the items on the Addendum.

CARRIED

DECLARATIONS OF CONFLICT OF INTEREST
There were no declarations of conflict of interest.

i) **Supplementary Document for the Board of Health Presentation:** ***Inquest into the deaths of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor***

- Verdict of Inquest Jury: 2021 Blastomycosis Outbreak in Constance Lake: Jury Recommendations Relevant to Local Public Health Agencies

The document, referenced during today's delegation, summarized what Public Health Sudbury & Districts is doing for the various public health-related recommendations resulting from the coroner's inquest.

ii) **City of Greater Sudbury Council Advocacy – Public Health Funding**

- City of Greater Sudbury Council Resolution dated November 25, 2025

M. Signoretti shared that the City of Greater Sudbury Council passed a motion to advocate for increased public health funding. It was noted that the Council unanimously passed the motion advocating to the province and Premier for viability and sustainability of public health funding per current 75/25 funding formula.

9. IN CAMERA

10-26 IN CAMERA

MOVED BY BARCLAY – MAZEY THAT this Board of Health goes in camera to deal with information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them.

Time: 2:54 p.m.

CARRIED

10. RISE AND REPORT

11-26 RISE AND REPORT

MOVED BY PARENT – BRABANT: THAT this Board of Health rises and reports.

Time: 3:13 p.m.

CARRIED

It was reported that one matter was discussed to deal with information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them. The following motion emanated:

12-26 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY BRABANT – BARCLAY: THAT this Board of Health approve the meeting notes of the November 20, 2025, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

11. ANNOUNCEMENT

- January 25, 2026, Board of Health meeting evaluation

Board members were invited to complete the evaluation for today's Board meeting.

- Board of Health Unlearning Club

Board members were reminded of the Board Unlearning Club session to be held immediately following today's meeting and that they can participate in person or virtually.

- Board Vacancy – Joint Board/Staff Accountability Working Group

There continues to be a Board of Health member vacancy on the Joint Board of Health/Staff Accountability Working Group. Amy Mazey offered to join the Working Group and the Board thanked her for her commitment.

- Annual Requirements for Board of Health members By-law has annual requirement that each BOH member review P&P

The Board of Health by-laws have an annual requirement that each Board of Health member review the Code of Conduct and Conflict of Interest Policies and Procedures. The Chair reviewed the duties and obligations of the Board members and noted the importance of leading by example. Board members are asked to complete the Code of Conduct and Conflict of Interest declaration forms once they have reviewed the Policies and Procedures.

- Next Board of Health Meeting

The next regular Bord of Health meeting will be held on Thursday, February 19, 2026, at 1:30 p.m.

12. ADJOURNMENT

13-26 ADJOURNMENT
MOVED BY MAZEY – CARRIER: THAT we do now adjourn. Time: 3:18 p.m.

CARRIED

_____ _____

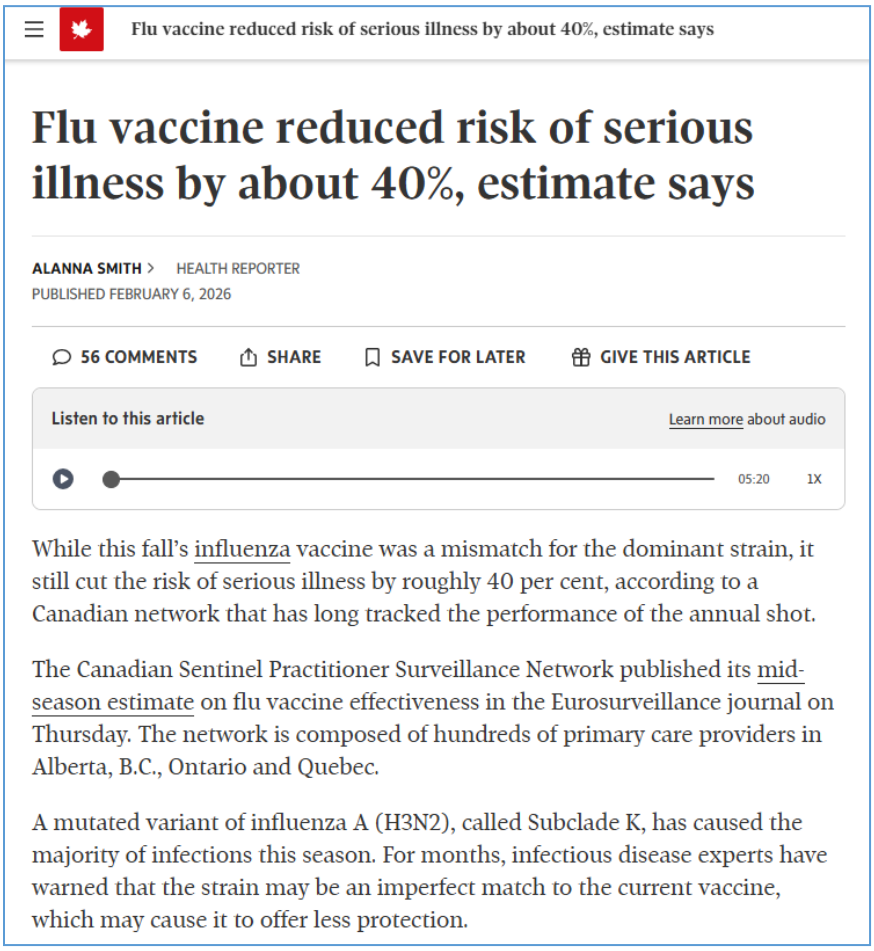
(Chair) (Secretary)

Public Health
Santé publique
SUDBURY & DISTRICTS

Medical Officer of Health/Chief Executive Officer Board of Health Report, February 2026

Words for thought

Flu Vaccine Reduced Serious Illness by 40%



Flu vaccine reduced risk of serious illness by about 40%, estimate says

Flu vaccine reduced risk of serious illness by about 40%, estimate says

ALANNA SMITH > HEALTH REPORTER
PUBLISHED FEBRUARY 6, 2026

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05:20 1X

While this fall's influenza vaccine was a mismatch for the dominant strain, it still cut the risk of serious illness by roughly 40 per cent, according to a Canadian network that has long tracked the performance of the annual shot.

The Canadian Sentinel Practitioner Surveillance Network published its mid-season estimate on flu vaccine effectiveness in the Eurosurveillance journal on Thursday. The network is composed of hundreds of primary care providers in Alberta, B.C., Ontario and Quebec.

A mutated variant of influenza A (H3N2), called Subclade K, has caused the majority of infections this season. For months, infectious disease experts have warned that the strain may be an imperfect match to the current vaccine, which may cause it to offer less protection.

There is much public attention around the concept of a mismatch of a vaccine and the circulating virus, but from a scientific standpoint, that concern is exaggerated. The match is only one of many factors that impact the effectiveness of a virus, and so, a mismatched vaccine isn't necessarily less effective at protecting people. In fact, some years, the vaccine manufacturers intentionally mismatch the vaccine slightly because the closer match proves less effective at generating a strong immune response. Nonetheless, when there is a mismatch it is a cause for concern that the vaccine might be less effective. Fortunately this past year, the vaccine has still proven to be in the mid-range for effectiveness.

Mismatch of vaccine occurs because the vaccine contents are decided in February by the World Health Organization to provide enough lead-time to vaccine manufacturers to produce the vaccine by the fall when the vaccines roll out. Sometimes the virus evolves during that period of time. Indeed that is what happened this year.

In February 2025, the so-called J.2 subclade was the dominant H3N2 Influenza A virus, and so this became one of the three components of the vaccine (two other subtypes were also included). However, by June, the dynamics of the virus had changed, and the now so-called subclade K was dominant. However, the vaccines were already in the pipeline, and it could not be changed. Fortunately, the vaccine still worked well.

There is promise that new vaccine technology, particularly mRNA vaccines, will shorten the timeline to produce vaccines, allowing a later date to determine the vaccine contents. That could mean that we might be able to select the vaccine components in June rather than February, increasing the likelihood of a better match.

Moderna has just developed a new influenza mRNA vaccine and has now submitted it for licensing. Canada, Australia, and the European Union are currently reviewing it and hopefully we will have access to this vaccine next fall. The US, however, has refused to consider the new vaccine (*F.D.A. Refuses to Review Moderna Flu Vaccine*, New York Times) claiming it has not been appropriately studied. This claim is largely incorrect.

The new vaccine is targeted to older adults. And for the subset of the most elderly who are also the most vulnerable to influenza, there are particular influenza vaccine products particularly tailored to work better in the elderly, though all influenza vaccines are effective. The US government's claim, if we interpret it in the most charitable light, is that the new vaccine should have been compared to one of these tailored vaccines rather than the standard vaccine as the research studies did. However, the age group studied in the vaccine trial was larger than the group recommended to receive the tailored vaccine, with the average age of participants below the threshold for the tailored vaccine. So the standard vaccine makes sense to use as the comparator.

The research trial (*A Study of mRNA-1010 Seasonal Influenza Vaccine in Adults 50 Years Old and Older*, National Library of Medicine) found an equivalent number of illness with each vaccine: 142 (1.3%) participants who received the standard vaccine versus 140 (1.3%) who received the new mRNA vaccine. Serious adverse events were also similar (4.4% versus 4.6% of participants). While careful review of the data needs to occur to determine whether the vaccine should be licensed, on its face, this vaccine appears to be similar effectiveness to other influenza vaccines and deserves careful review. If it is approved, it may allow us to have better matched vaccines given shorter production timelines.

It is unfortunate that the US government is ideologically opposed to mRNA vaccines and is rejecting them, preventing a possible improved vaccine to benefit the health of people.

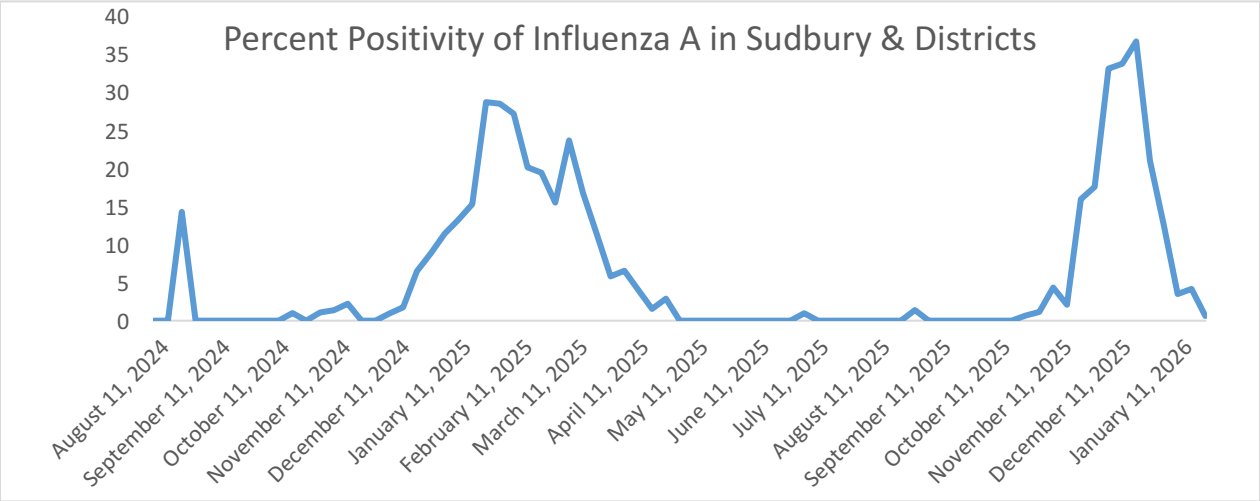
Source: Flu vaccine reduced risk of serious illness by about 40%, estimate says - The Globe and Mail

Date: February 6, 2026

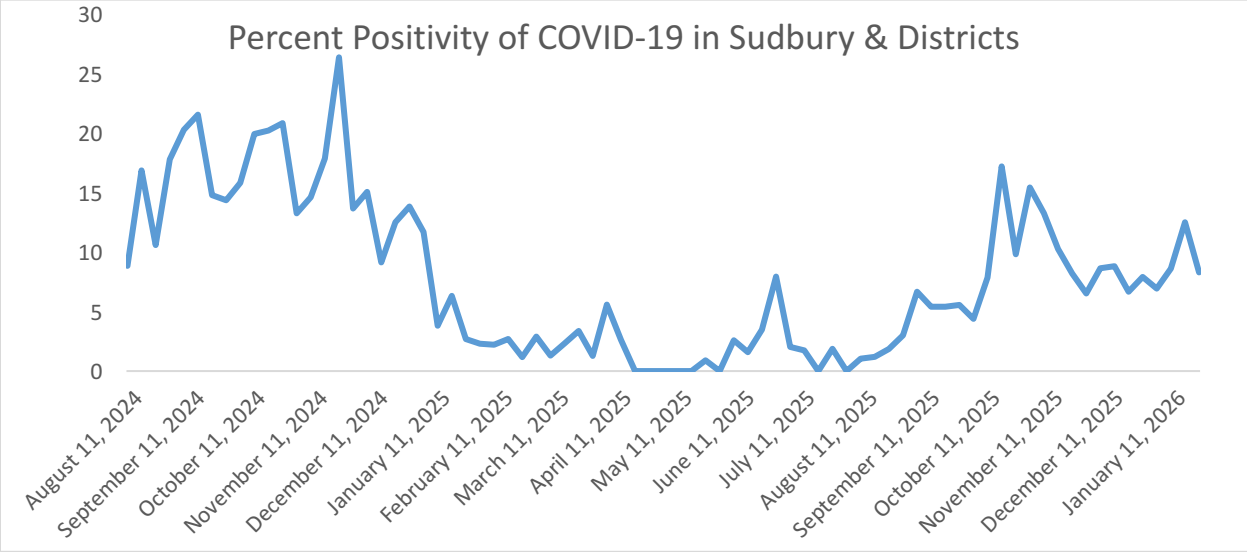
Report Highlights

1. Respiratory Virus Season

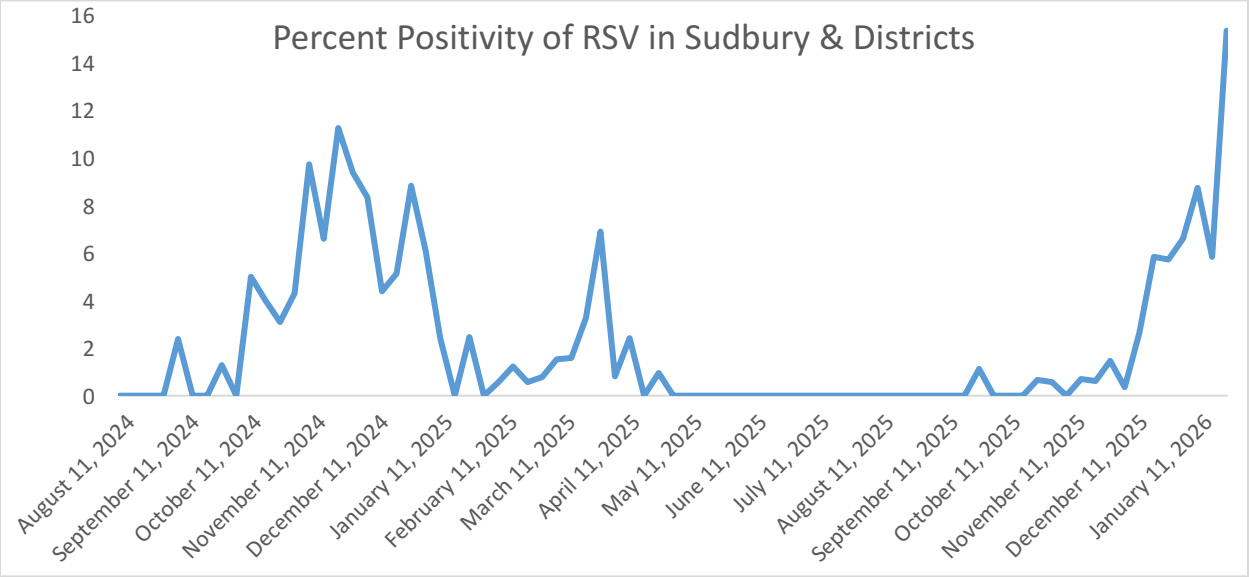
The annual winter wave of influenza A virus seems to have come to an end. This year's influenza A wave came early, and also had a rapid rise and rapid fall. Each spring, there is then an influenza B virus wave that is less severe but still deadly for children and elderly persons, so we remain vigilant about that.



COVID-19 has risen through the fall and winter. This is a partial change from recent years which has seen the wave begin in the summer and then continue through the fall and winter. This year has also seen a smaller rise than in past years. The pattern of COVID-19 has been somewhat unpredictable, so we remain vigilant to a potential increase.



Respiratory syncytial virus (RSV) is also on its annual rise. Thanks to immunization now available for the elderly and infants, we saw a sharp drop in RSV infections and hospitalizations last year. While the season is trending worse this year in the Sudbury and Manitoulin districts, that isn't the case for Ontario as a whole, and we remain hopeful that we are approaching a peak (there are some signs to support this), and will see overall reduced infections and hospitalizations again this year.



2. *Immunization of School Pupils Act* (ISPA) Implementation

The consistent, annual implementation of ISPA is critical for maintaining high vaccination levels among school-aged children, preventing school outbreaks that disrupt the learning of students, helping children stay healthy and thrive.

2026 will see process changes for this work with both greater use of technology to streamline processes saving money, and a harmonized calendar across our entire service area. In December and January, Public Health issued 2947 final notices for incomplete or overdue immunization records to elementary and secondary students. Over 30% of those students have now ensured they have required vaccines. Work will continue around this to avoid suspension of students in March who do not have records on file of having completed needed vaccinations. Upon suspension, Public Health will support those students to get vaccinated as quickly as possible so they can get back in the classroom.

3. Electronic Medical Record (EMR)

With the support of the significant support provided by the Board in the 2026 operating budget ($711,434), Public Health is moving expeditiously to get programs onboarded to the new electronic medical record (EMR). The first program, Healthy Families, has now switched over to the EMR from paper charts. A public notice was issued to advise the community of how they will see services evolve due to the EMR.

The agency's goal is to complete the transition from paper charts to the EMR for all programs by the end of 2026.

4. IT Enhancements

With the significant one-time investments the Board of Health made in technology and artificial intelligence, the agency has been moving swiftly to implement the IT roadmap and AI use cases, as well as roll-out a new human resources and payroll system. The IT team has been grown to full complement for the first time in years. Cybersecurity upgrades are already taking place, and updated hardware for our systems has been procured. Migrating to more modern systems is occurring in the next quarter. Finally, enterprise-grade AI tools have now been rolled out to all staff to facilitate their efficiency.

5. Lakelands Public Health Cybersecurity Attack

Lakelands Public Health (based around Peterborough) is the latest local public health agency to be hit with a major cyberattack which has significantly affected their operations. This is the latest local public health agency to have had a major cyberattack. Other recent cyberattacks include Durham (2021) and Hamilton (2024). This cyberattack emphasizes the importance of the investments the agency is making this year to strengthen its cybersecurity posture.

6. Outcome-Oriented Program Planning

The agency is currently undertaking its first-round of reorienting program planning around outcomes. This represents a shift from the historical focus, driven by the Ministry of Health, to plan based on compliance with Ontario Public Health Standards and provincial mandates. While this has been the Ministry of Health's focus, we hear that it has not served to demonstrate the value of public health during provincial budget conversations. Shifting to outcome-oriented planning will support the Agency to better measure and improve its impact on the health of the public, while also enabling better demonstrating the agency's value to the Board, the provincial government, and the public.

7. Elm Place Signage and Wayfinding

In partnership with the Elm Place Mall, Public Health has installed comprehensive new signage and wayfinding for our clinic at Elm Place Mall. This will ease our clients finding our clinics, and improve our visibility to the public who visit the mall.

General Report

1. Board of Health

Board of Health Membership

A warm welcome to Tom Trainor, who has been appointed by the Lieutenant Governor in Council as a provincial appointee to the Board of Health for Public Health Sudbury & Districts. With this appointment, the Board currently has two provincial appointees. Under section 49(3) of the *Health Protection and Promotion Act* (R.S.O. 1990, c. H.7), the Lieutenant Governor in Council may appoint one or more members to a Board of Health, provided that the number of provincial appointees is fewer than the number of municipal members. Based on the current composition of the Board of Health for Public Health Sudbury & Districts, this provision permits up to 10 provincial appointees.

An orientation session will be held on February 18, 2026, for T. Trainor.

Declaration Forms

All Board of Health members are required to review the Board of Health Code of Conduct and Conflict of Interest policies and procedures annually and complete the declaration forms confirming they have completed their review. Reminders will be sent to Board of Health members who have not had a chance to review these and complete the corresponding declaration forms.

alPHa Winter Symposium and Workshops

M.M. Hirji as well as Board of Health member Robert Barclay are attending alPHa's 2026 Winter Symposium and Workshops February 11 to 13, 2026. The event provides members with engaging online workshops and in-depth plenary sessions with prominent public health leaders on the importance of Ontario's local public health system.

2. Human Resources

Recruitment efforts are ongoing for a permanent part-time (0.6 FTE) Associate Medical Officer of Health to complement our current permanent part-time (0.4 FTE) Associate Medical Officer of Health.

3. Accountability Monitoring Plan

On February 2, 2026, the Joint Board of Health/Staff Accountability Working Group met to review the draft 2025 annual Accountability Monitoring Report.

The annual *2025 Accountability Monitoring Report* will be presented to the Board of Health at its February 2026 meeting. The results presented in the *2025 Accountability Monitoring Report* illustrate continued progress on organizational requirements, Foundational and Program Standards Requirements, and measures related to the agency's Strategic Plan.

4. Quarterly Compliance Report

The agency is compliant with the terms and conditions of our provincial *Public Health Funding and Accountability Agreement*. Procedures are in place to uphold the Ontario Public Health Accountability Framework and Organizational Requirements, to provide for the effective management of our funding and to enable the timely identification and management of risks. Public Health Sudbury & Districts has disbursed all payable remittances for employee income tax deductions, Canada Pension Plan and Employment Insurance premiums, as required by law to January 30, 2026, on February 2, 2026. The Employer Health Tax has been paid, as required by law, to December 31, 2025, with an online payment date of February 13, 2026. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to January 31, 2026. There are no outstanding issues regarding compliance with the *Occupational Health & Safety Act*, the *Employment Standards Act* or the *Accessibility for Ontarians with Disabilities Act*. However, there is one matter currently before the Ontario Human Rights Tribunal.

5. Electronic Medical Records

The Electronic Medical Records (EMR) implementation continues to progress steadily and remains on track, with no significant risks affecting program onboarding or the December 2026 completion target. Healthy Babies Healthy Children successfully went live on January 27, 2026, while Control of Infection Diseases began discovery on January 29, 2026, and is advancing toward an early-April go-live.

Resource stability remains a project strength, supported by the recruitment of a permanent Medical Informatics Specialist and expanded staff tools within the EMR Learning Hub, including onboarding guides, training materials, a discussion board, and a formalized pathway for EMR Profile support, ticketing, and escalation.

Change management activities continue to focus on building awareness and readiness across programs through coordinated communications, and the development of an Internal EMR Community of Practice to reinforce ongoing learning and adoption.

Following are the divisional program highlights.

Health Promotion and Vaccine Preventable Diseases Division

1. Chronic Disease Prevention and Well-Being

Seniors Dental Care

Staff continued to provide comprehensive dental care to clients at the Seniors Dental Care Clinic at Elm Place, including restorative, diagnostic, and preventive services. Staff also provided client referrals to contracted community providers for emergency, restorative, or prosthodontic services, as well as enrollment assistance for low-income seniors eligible for the Ontario Seniors Dental Care Program.

2. Healthy Growth and Development

Infant Feeding

Public health nurses delivered 77 clinic appointments to support clients with infant feeding across the service area, empowering parents to make informed choices about how to feed their baby. The clinic offers inclusive support for both breastfeeding and formula feeding, promoting healthy growth and development. Nurses complete assessments to identify potential concerns early, such insufficient milk supply, and monitor infant weight gain and growth to ensure infants are progressing as expected.

Growth and development

Public health nurses completed 102 postpartum follow-up calls with parents of newborns within 48 hours of hospital discharge. These calls provided support related to infant feeding and postpartum recovery and helped connect families with community resources that promote healthy early growth and development. In addition, 42 reminder postcards were sent to encourage parents to book the important 18-month well-baby visit with their health care provider, which supports a growth and development assessment, early intervention and referrals as needed before school entry.

Health Information Line

The Health Information Line responded to 71 calls from community members on a range of topics, including infant feeding, healthy pregnancies, positive parenting, healthy growth and development, and mental health services. Staff also assisted callers with questions related to infectious disease prevention and access to primary health care providers, and helped connect residents with appropriate services and supports.

Healthy Babies Healthy Children

Through the Healthy Babies Healthy Children Program, public health nurses and family home visitors supported 13 new families and completed 146 follow-up visits, providing ongoing support to families with young children. The program provides tailored guidance, home visits, and community referrals to help families nurture healthy child development, strengthen parenting skills, and build supportive home environments.

Healthy pregnancies

A total of 20 individuals enrolled in the InJoy online prenatal e-class, an interactive platform designed to help expectant parents prepare for life with a new baby. Participants explored topics such as infant feeding, self-care, nutrition, the impact of a new baby on relationships, and labour and delivery.

3. School Health

Oral Health

Staff continued to deliver the annual school-based oral health assessment and surveillance program, and completed case management follow-ups for children with urgent dental care needs. Staff also provided program enrollment assistance to families interested in applying for Healthy Smiles Ontario (HSO).

4. Substance Use and Injury Prevention

Substance Use

On December 2, 2025, Public Health issued a drug warning in response to an observed increase in drug poisonings (overdoses) and unexpected reactions to substances circulating in the Sudbury and Manitoulin districts. Rapid responses to adverse drug reactions or newly circulating substances help protect the public and mitigate further harm.

Ahead of Dr. Hirji's presentation to the Community Emergency Services Committee, Public Health responded to a CBC media request on November 19, 2025, to discuss the Community Drug Strategy for the City of Greater Sudbury, the current local substance use situation, and the statistical overview shared with the City of Greater Sudbury. Public Health also responded to two additional media inquiries, including an interview with Radio-Canada regarding cyclorophine, and a January 6, 2026, interview with CTV Northern Ontario about overdose deaths in the service area.

On December 18, 2025, approximately 70 people attended an information session on implementing Planet Youth's Icelandic Prevention Model (IPM) in Sudbury and LaCloche areas. Planet Youth is a long-term, community-led model designed to prevent youth substance use by listening to young people, supporting families, and creating safe, positive places for youth. The

model uses local survey data to identify youth needs and helps communities take evidence-informed action to support youth well-being.

Partners at the session represented a variety of sectors, including education, health care, justice, research, mental health, government, and cultural organizations. They identified that the building blocks for success are already in place, including strong community relationships and a clear willingness to work together. The community has an opportunity to transform these strengths into a coordinated, evidence-informed prevention framework.

Harm reduction – Naloxone

Public Health Sudbury & Districts has signed 48 Memorandum of Understandings with community partners for naloxone distribution. Staff continue to support these partners with distribution and training. In December, a total of 1142 naloxone doses were distributed, and 95 individuals received training on its use.

5. Vaccine Preventable Diseases

Immunization information line

In January, staff responded to approximately 800 calls through the immunization information line. Most inquiries related to the *Immunization of School Pupils Act* (ISPA) and seasonal vaccines, including influenza, COVID-19, and respiratory syncytial virus (RSV). Staff assisted callers with accessing immunization records and provided general vaccine information.

Publicly funded immunization programs

Public Health continues to provide publicly funded vaccines to clients experiencing barriers to primary care, including those without a health card. Appointment based and drop-in clinics remain available to help students stay up to date with vaccines required for school attendance.

Immunization of School Pupils Act (ISPA) and Child Care and Early Years Act (CCEYA)

Public Health issued 2947 final notices for incomplete or overdue immunization records to elementary and secondary students. More than 30% of students who received at least one notice are now up to date. Public Health continues to work with school communities, parents and guardians, and primary care providers to support timely reporting, informed vaccination decisions, and improved compliance with vaccination requirements for school attendance.

Vaccine Distribution and Cold Chain

Public Health continues to ensure safe and timely vaccine distribution to providers and provides ongoing education to help maintain proper vaccine storage and handling across the service area. Staff also encourage timely reporting of cold chain incidents to support effective vaccine administration and improve immunization coverage.

Health Protection

1. Control of Infectious Diseases (CID)

In the month of January, staff investigated 92 sporadic reports of communicable diseases, including two reports of *Legionella pneumophila*. The Public Health investigation determined that these Legionella cases are epidemiologically linked. The likely exposure occurred outside our catchment area, and the appropriate Local Public Health Agency has been informed of the cluster. The exposure source was likely a personal hot tub at a private residence. No additional cases are anticipated to be linked with this cluster.

During this timeframe, 19 respiratory outbreaks were declared. The causative organisms for the respiratory outbreaks were identified to be: COVID-19 (6), influenza A (4), human coronavirus (1), RSV (1) and rhinovirus (1). The causative organism for the remaining respiratory outbreaks were not identified.

Staff continue to monitor all reports of enteric and respiratory diseases in institutions, as well as sporadic communicable diseases.

During the month of January, six infection control complaints were received and investigated and ten requests for service were addressed.

Infection Prevention and Control Hub

The Infection Prevention and Control Hub provided 201 services and supports to congregate living settings in January. These included proactive IPAC assessments, education sessions, feedback on facility policies, and supporting congregate living settings in developing and strengthening IPAC programs and practices, to ensure that effective measures were in place to prevent transmission of infectious agents.

2. Food Safety

During the month of January, public health inspectors issued one closure order to a food premises due to cockroaches being observed.

3. Health Hazard

In January, 11 health hazard complaints were received and investigated. Further, staff provided 14 consultations in response to health hazards that are not part of the public health mandate and redirected clients to the most appropriate lead agency for investigative follow-up.

Staff continue to participate in the following City of Greater Sudbury working groups:

- Energy Court Governance Committee
- Multi Dwelling Unit Utility Disconnect Task Fource

Furthermore, staff participate on the Rapid Mobilization Table (RMT) hosted by the Canadian Mental Health Association (CMHA). The RMT is a multi-sectoral community partnership representing key sectors who respond to situations involving persons in the community who are at acutely elevated risk of harm to themselves, including becoming unhoused.

Being a part of these working groups allows Public Health to ensure continual networking with key community partner agencies, and to ensure that public health aspects are being brough forward in discussions.

4. Ontario Building Code: Septic System Inspections & Approvals

In January, two sewage system permits, four renovation applications, and two consent applications were received.

5. Rabies Prevention and Control

In January, 29 rabies-related investigations were conducted. Three specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis. At the time of this report, one result was pending, and two were reported as negative.

Six individuals received rabies post-exposure prophylaxis following an exposure to wild or stray animals.

6. Safe Water

During January, 20 residents were contacted regarding adverse private drinking water samples. Additionally, public health inspectors investigated three regulated adverse water sample results.

One boil water order was issued and subsequently rescinded following corrective actions. One drinking water order was issued. Furthermore, one closure order of a public pool was also issued due to no available disinfectant in the water.

7. Smoke-Free Ontario Act, 2017 Enforcement

In January, *Smoke-Free Ontario Act* Inspectors issued seven warning letters to individuals for vaping on school property.

8. Vector Borne Diseases

In January, one tick was submitted to the Public Health Ontario Laboratory for identification. At the time of this report, the result was pending. Infected blacklegged ticks are vectors of Lyme disease and other tick-borne diseases.

9. Needle/Syringe Program

In December, harm reduction supplies were distributed, and services received through 1635 client visits across our service area. Public Health Sudbury & Districts and community partners distributed a total of 22 487 syringes for injection, and 59 663 foils, 13 795 straight stems, and 4 073 bowl pipes for inhalation through both our fixed site at Elm Place and outreach harm reduction programs.

In December, approximately 17 734 used syringes were returned, which represents a 69% return ratio of the needles/syringes distributed in the month of November.

10. Sexual Health/Sexually Transmitted Infections (STI) including HIV and other Blood Borne Infections

Sexual health clinic

In January, there were 142 drop-in visits to the Elm Place site related to sexually transmitted infections, blood-borne infections and/or pregnancy counselling. As well, the Elm Place site completed a total of 313 telephone assessments related to STIs, blood-borne infections, or pregnancy counselling in January, resulting in 119 onsite visits.

Knowledge and Strategic Services

1. Health Equity

Throughout December and January, a training series on Anti-Racism and Anti-Oppressive (ARAO) practice was offered to Public Health staff. The training aligns with our strategic priority of Equal Opportunities for Health and advances the capacity-building component of our agency's *Racial Equity Action Framework*, while also complementing the Unlearning and Undoing White Supremacy & Racism Project. In recognition of Black History Month, additional internal learning opportunities are being promoted in February to deepen staff understanding and engagement in ARAO practice and to enhance awareness of ongoing internal efforts to implement the agency's Framework. Together, these initiatives help strengthen ARAO capacity across the organization, build practical skills that contribute to equity-oriented practices, and reinforce our commitment to advancing racial equity and fostering culturally safe spaces for communities and partners across Sudbury and districts.

2. Population Health Assessment and Surveillance

In January, the Population Health Assessment and Surveillance team responded to 22 internal and external requests for data, information, and consultations, in addition to supporting routine surveillance and reporting.

The team continued to collaborate with the Vaccine Preventable Disease (VPD) team to support their processes, and identified the need for a more efficient *Immunization of Schools Pupils Act* (ISPA) enforcement letter process. Building on earlier work in collaboration with Wellington Dufferin Guelph in 2025 for the *Child Care and Early Years Act* (CCEYA) and ISPA letters, the team worked with VPD to develop a process that streamlined letter generation. As a result, all enforcement letters were generated, reviewed, and mailed within one week, significantly improving communication speed and coordination.

3. Effective Public Health Practice

A member of the Effective Public Health Practice team presented two National Collaborating Centre for Healthy Public Policy webinars in January with research colleagues. The webinar titled *Building Healthy Public Policy: Measuring Your Progress* had significant national interest with over 650 participants registered for the English webinar and over 270 participants registered for the French webinar.

Program data was collected and collated for the Ministry of Health Standard Activity Report, which reflected services and activities from January to December 2025. Public health unit data from these reports are now available for viewing in a dashboard format for benchmarking and internal planning.

4. Communications

New and improved storefront signage has been designed and installed in Elm Place for the Sexual Health Clinic, Seniors Dental Care Clinic, and The Point (harm reduction supplies and services). The new signage reflects Public Health's commitments to inclusivity and positive space, creating a welcoming space for all. This signage significantly improves wayfinding for clients and is complimented by new digital maps installed by the mall.

Respectfully submitted,

M. Mustafa Hirji, MD, MPH, FRCPC
Medical Officer of Health and Chief Executive Officer

Northeastern
PUBLIC HEALTH
SANTÉ PUBLIQUE
du Nord-Est

January 14, 2026

The Right Honourable Mark Carney, Prime Minister of Canada
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: PM@pm.gc.ca

The Honourable Doug Ford, Premier of Ontario
Legislative Building Queen's Park
Toronto, ON M7A 1A1
Sent via email: Premier@ontario.ca

Dear Prime Minister Carney and Premier Ford

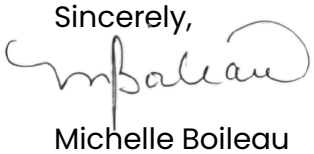
Re: Highway Safety in Northern Ontario

Highway safety in Northern Ontario has been a long-standing concern for Northern communities with tremendous tragic losses of beloved community members, impacts on local economies with frequent inability to access to work, education and necessary social and health care services. In addition, the Board of Health for the Northeastern Health Unit has seen the negative impacts and delays in emergency response systems during public health emergencies across the region. Please find enclosed a resolution along with a Briefing report outlining issues, impacts to public health, evidence and key recommended interventions for the improved development of Northern highways.

The Board of Health respectfully requests careful and urgent consideration of options to address highway safety and accessibility. While ensuring the same standards are available at minimum for residents of Northern Ontario would be preferred with four lane highways that are consistently cleared, FONOM's letter *A Nation-Building Case for a 2+1 Highway for enhanced east-west Canadian trade* issued by the Federation of Northern Ontario Municipalities (FONOM), shared important options for consideration. The Northern population already experiences poorer health outcomes on most indicators compared to the rest of the province, and prioritizing highway safety and accessibility across Northern Ontario is critical to protecting and preserving the health of our communities.

On behalf of the Board of Health, thank you for the attention that you will give to this report.

Sincerely,



Michelle Boileau
Chair, Board of Health
Northeastern Public Health

Copies to:
Right Honourable Mark Carney, Prime Minister of Canada
The Honourable, Steven Mackinnon, Minister of Transportation
Honourable Doug Ford, Premier of Ontario
Honourable Prabmeet Sarkaria, Minister of Transportation
Honourable Jill Dunlop, Minister of Emergency Preparedness and Response
Honourable Sylvia Jones, Minister of Health
Honourable Paul Calandra, Minister of Education
Honourable Michael S. Kerzner, Solicitor General
Honourable George Pirie, Minister Northern Economic Development and Growth, Member of Provincial Parliament – Timmins
Guy Bourgoin, Member of Provincial Parliament – Mushkegowuk – James Bay
John Vanthof, Member of Provincial Parliament – Timiskaming - Cochrane
Bill Rosenberg Member of Provincial Parliament – Algoma – Manitoulin
Dr. Kieran Moore, Chief Medical Officer of Health (CMOH)
NEPH member municipalities
Commissioner Thomas Carrique, Ontario Provincial Police
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Board of Health for the Northeastern Health Unit

Encl: Northeastern Public Health Resolution BOH – 2025-R-51 Improving Highway Safety and Equity in Northern Ontario Early
Northeastern Public Health Briefing Note – Northern Highways
Federation of Northern Ontario Municipalities A Nation Building Case for a 2+ 1 Highway for Enhanced east-west Canadian Trade

October 23, 2025

SUBJECT: Improving Highway Safety and Equity in Northern Ontario

At the October 23rd meeting, the Board of Health for the Northeastern Health Unit, supported this motion to highlight the need to address Northern highway safety.

The following motion was read:
MOVED BY: Andrew Marks
SECONDED BY: Jeff Laferriere

Board of Health Resolution #BOH-2025-R-51

WHEREAS Highway safety is a critical public health issue in Northern Ontario, where long distances between communities, severe weather, heavy commercial transport traffic, and wildlife hazards increase risks for residents, service providers, and emergency responders. Spanning more than 11,000 kilometres, Highways 11, 17, 101, and 144 serve as lifelines, connecting Northeastern communities to the rest of the province (2). These routes are vital links in the Trans-Canada Highway system, providing essential access to health care, education, employment, and basic services (1,2); and,

WHEREAS From 2018 to 2022, emergency department visits for motor vehicle collisions in the Northeastern Public Health (NEPH) region were consistently 1.6 to 2.0 times higher than the Ontario average, highlighting both the region's elevated collision risk and its heavy reliance on these critical corridors (8); and,

WHEREAS The Northern region records the highest rate of large-truck collisions in Ontario - 94% higher than the next highest region and over three times higher than the lowest – as well as the highest fatality rate from motor vehicle collisions, 27.8% above the next highest region and 15.5 times higher than the lowest (7,8).; and, serious and fatal collisions along with prolonged road closures, hinder access to goods and essential services, delay emergency response and jeopardize the well-being and safety of Northern Ontaria

WHEREAS Northern communities, including Indigenous and First Nation communities and Francophone populations (32.8% Francophone, 17.5% Indigenous), face significant barriers to health care that are intensified by highway closures, isolating residents from emergency care and essential services. These inequities are further exacerbated for First Nations and Indigenous peoples, rooted in historical trauma and reflected in ongoing disparities in access to care, essential services, and overall health outcomes (3,4,5). Unsafe and unreliable highways deepen these inequities, threaten community well-being, and widen gaps in overall health and quality of life; and,

WHEREAS Limited access to primary care and medical specialists further compounds the challenge. In 2022–2023, more than 170,000 Northern Health Travel Grants were issued to assist 66,000 residents with travel and accommodation for medical needs, demonstrating the region's dependence on long-distance highway travel for essential health care (6); and,

WHEREAS Each year, Northern Ontario roads experience increasing numbers of drivers and collisions, traveling on highways that are substandard, outdated, and unsafe (1). Every day, more than 8,400 trucks transport over $200 million in goods across these same routes, which have limited passing lanes, inadequate shoulders, and numerous high-collision zones (10). Current highway designs lack sufficient median separation, safe passing lanes, and refuge zones, increasing the risk of head-on collisions and dangerous overtaking, especially under winter conditions; and,

WHEREAS Investing in safer Northern Ontario highways is a matter of health equity(10). Residents of Northern Ontario and First Nation communities deserve the same level of safety, accessibility and opportunity as those in southern regions, and the continued loss of life on unsafe roads is unacceptable (9, 10).

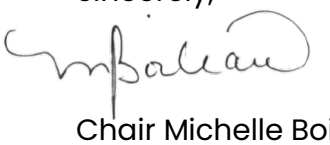
WHEREAS FONOM and Northern municipalities propose the 2+1 upgrade on Highways 11 and 17, including *North Bay to Cochrane* and *Renfrew to Sudbury* in Phase 1, and *Cochrane to Nipigon*, *Thunder Bay to Kenora*, and *Sault Ste. Marie to Sudbury* in Phase 2 recognizing this alternating passing lane design with a crash-rated median barrier is proven, safe and cost-effective fit for Northern Ontario, and reducing fatal crashes by up to 76% (10);

NOW THEREFORE BE IT RESOLVED THAT The Board of Health for the Northeastern Health Unit calls upon the Government of Ontario and Canada to prioritize highway safety and equity across Northern Ontario by:

1. Committing to the full, phased implementation of the 2+1 highway model along Highways 11, 144 and 17 as a priority investment in safety and health equity
2. Collaborating with northern Municipalities, First Nation communities and urban First Nation, inuit and Metis partners to ensure infrastructure planning incorporates health, safety and equity considerations.
3. Designating high-collision and high-risk zones for safety upgrades, with priority for sections that affect emergency response, health-care access, and the delivery of essential goods and services.

CARRIED AS PRESENTED

Sincerely,



Chair Michelle Boileau,
Board of Health for the Northeastern Health Unit

Copies to: Right Honourable Mark Carney, Prime Minister of Canada
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Honourable Paul Calandra, Minister of Education
Honourable Michael S. Kerzner, Solicitor General
Honourable George Pirie, Minister Northern Economic Development and Growth, Member of Provincial Parliament – Timmins
Guy Bourgoin, Member of Provincial Parliament – Mushkegowuk – James Bay
John Vanthof, Member of Provincial Parliament – Timiskaming - Cochrane
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Association of Local Public Health Agencies (alPHa)
Board of Health for the Northeastern Health Unit

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Briefing Note:
Northern Highways

Issue

Northern Ontario highways pose serious risks. Dangerous single lane designs, narrow winding roads, unpaved shoulders, harsh winters, and limited emergency access (i.e. poor cellular service, intermittent patrols, few exits and rest stops). Northern highways carry heavy-load commercial vehicles and residents who rely on them for specialized and life-saving medical care, amenities, employment and education (1, 2). Alongside serious and fatal collisions, prolonged road closures and delays hinder timely access to goods and essential services, slow emergency response time with concern for timely life saving measures and overall well-being of Northern Ontarians.

Background

Road safety is not just a concern – it is a critical public health issue. Every year, Northern Ontario roads see more drivers, and more collisions (1). Northern Ontario highways span over 11, 000 km, with highways 11, 17, 101 and 144 serving as lifelines connecting Northeast communities to the rest of the province (2). These highways are crucial links in the Trans-Canada highway and essential routes for residents who need access to healthcare, education and basic services.

The Impact on Public Health:

During the COVID-19 pandemic and a blastomycosis outbreak in a remote First Nation community, Northern Ontario's single-road access to remote communities failed. A three-day highway closure delayed critical healthcare and access to supplies. Throughout the pandemic, vaccine shipments were constantly at risk from road conditions, and healthcare workers faced dangerous commutes to reach isolated communities.

- The Northeastern region is shared with 11 First Nations, many without road access (3, 4).
- **Rural and Vulnerable Populations:** Higher rates of residents who identify as Francophone (32.8% vs. 3.3% Ontario), Indigenous (17.8 % vs. 2.9% Ontario) (4). The Northeastern Public Health (NEPH) area has a larger rural population (32.9%) compared to the province (13.3%) (17, 18).
- **Poorer Overall Health:** Elevated rates of chronic disease and preventable deaths (associated factors such as smoking and substance use, increased cost of living, and lack of affordable nutritious foods) (5).

- **Lack of Healthcare Services:** 2.5 million in Ontario do not have a family doctor (16). In 2022-2023, about 170,000 Northern Health Travel Grants were issued for 66,000 residents' travel and accommodation needs (6).
- **Increase Use:** In just one year, the number of licensed drivers increased by 170, 877 individuals with a staggering total of 10, 877, 259 driving on Ontario roads in 2021 (1).

Current Status

The Ministry of Transportation has made some initial investments in Northern Ontario's highways, but it is not enough. These efforts are a start, but fall short to the actions needed:

- Expanding parts of Highways 11/17 and 69 (2).
- Piloting a 2+1 passing lane model on highway 11 (7).
- Improvements to and addition of rest areas (2, 8).
- Enhancements the Cochrane by-pass, 11 to 652 (2).

Winter highway clearing is inadequate. The MTO strives for 90% bare pavement, but in Northern Ontario, this translates to subpar standards that fall short of those in other areas of the province. In Northern Ontario, minor highways (servicing 401-800 vehicles per day) only require the center lanes to be cleared within 24 hours after a storm. For local highways (service an average 400 vehicles per day), the standard permits for snow-packed driving surfaces within 24 hours post-storm.

Minor improvements have been announced, yet none address the need for adequate clearing times to meet bare pavement standards, leaving safety compromised:

- 14 new Road Weather Information System (RWIS) stations for winter crews.
- Enhanced use of anti-icing liquids for highway snow clearing.
- Upgrades to the Ontario 511 app (limited cellular service restricts access to this app) (8).

Key Considerations

Human behaviour inevitably increases the risk of highway injuries and deaths with distracted driving, high speeds, substance impairment, and fatigue as major factors (9). In 2022, the Northern region led in motor vehicle collisions due to each of these causal factors: alcohol/drugs, distraction, seatbelt non-use, speed. The Northern region was higher by 2.5 to 4.6 times compared to other regions (10).

The Evidence

- **Injury Rates:** From 2018 to 2022, Northeastern ED visits due to motor vehicle collisions consistently exceeded the Ontario rate – 1.6 to 2.0 times higher than the Ontario average (2018-2022) (11).
- **Truck Collision:** The Northern region reported the highest rate of large trucks collisions in Ontario - 94% higher than the next highest region and 3.1 times higher than the lowest region (11).

- **Cost of Transport-Related Injuries:** In 2019, transport-related injuries in Ontario cost over $1.3. billion annually, with motor vehicle collisions accounting for the highest cost, even before pedestrian and cycling collisions (12).
- **Fatalities:** Between 2018 and 2022 the Northern region recorded the highest fatalities from motor vehicle collisions - 27.8% above the next highest region and 15.5 times higher than the lowest (10, 11).
- **Impact on Emergency Response:** Poor highway conditions and closures have repeatedly prevented paramedics from reaching their regional bases, jeopardizing emergency response:

"Ensuring our highways are properly maintained, especially in Northern Ontario, is critical for the safety of all road users. Improved highway cleaning and maintenance can significantly reduce the risk of motor vehicle collisions, which have devastating consequences for families and communities. Additionally, highway closures not only cost lives but also hinder our ability to respond to emergencies and assign paramedics where they are needed most. Keeping our highways clear is essential for saving lives and ensuring that emergency services can reach those in need without delay." *Marc Renaud, Chief (A) of Cochrane District Paramedic Service*

- **Essential Services Perspective:** Luc Mignault, a local business owner and tow truck operator, highlighted how lengthy highway closures severely impact safe, timely travel across Northern Ontario. Northern Ontario highways require commercial drivers to navigate unique challenges, including rapidly changing weather and remote, single-lane routes. To address these specific risks, additional training and education for drivers of heavy-load vehicles are essential, equipping them to respond safely to Northern Ontario's demanding conditions.
- Public Concern: A 2021 national survey found that road safety to be a top 5 priority of Canadians, yet fewer than half feel safe on our roads (39% vs 46%) (13).

Options

Vision Zero has cut road mortality by 68% in Sweden from 2000 to 2019 and by 50% in Edmonton between 2015 and 2021. A zero-tolerance approach to road injuries demands a system-wide commitment from policy makers, law enforcement, road users and roadway designers (14).

Key interventions are recommended for the improved development of Northern highways:

1. **Target High-Risk Areas:** Assess collision prone sites in the Northeast, especially where vulnerable road-users are at risk (15).
2. **Overhaul Winter Maintenance Standards:** Prioritize timely, effective winter clearing, especially in rural and remote areas and align Northern Ontario's bare pavement standards with the rest of the province. **Equitable standards across Ontario are essential to ensuring safe, accessible roads for all residents, no matter where they live.**
3. **Expand Emergency and Law Enforcement Presence:** Enhanced presence of emergency respondents and law enforcement, for effective intervention.
4. **Strengthen Road Safety Education:** Implement targeted education for both commercial and residential road-users, addressing specific risks on Northern Highways.
5. **Revise Emergency Response Plans:** Update plans for motor vehicle collisions where closures are expected to exceed 8-12 hours, ensuring readiness for extended incidents.

6. **Expand Cellular Coverage:** Commit to improving cellular infrastructure to ensure travelers can access emergency services and real-time updates.
7. **Implement 2+1 Road Designs:** Expand the piloting of 2+1 highway model with alternating passing lanes on major Northern routes to reduce head-on collisions and allow safer passing in high-traffic areas.
8. **Increase Lighting and Signage:** Install better lighting and clear, reflective signage on high-risk stretches to improve visibility, especially in winter conditions.
9. **Install Safety Measures:** Install safety features (i.e., barriers, rumble strips), to prevent vehicles from veering off-road and to reduce the severity of collisions.
10. **Expand and Enhance Rest Stops and Road Shoulders:** Increase the number of safe and accessible rest stops to reduce driver fatigue and support commercial and long-distance drivers. Improve road shoulders to provide essential space for emergency stops and safer travel. Appropriately maintained rest stops.

Conclusion

The built environment has direct impact on preventable road injuries and deaths. Moving to a Vision Zero framework requires action from policy makers and influencers to enact meaningful change. With increasing numbers of vulnerable road users in the Northeast, urgent improvements in infrastructure, highway maintenance, emergency response, and management of highway closures and delays are essential. **Northern Ontario's road safety crisis demands immediate, decisive action.**

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FONOM

Federation of Northern Ontario Municipalities

July 15, 2025

The Right Honourable Mark Carney Prime Minister of Canada

80 Wellington Street Ottawa, ON K1A 0A2

SENT BY EMAIL: PM@pm.gc.ca

The Honourable Doug Ford Premier of Ontario

Legislative Building, Queen's Park

Toronto, ON M7A 1A1

SENT BY EMAIL: Premier@ontario.ca

Dear Prime Minister Carney and Premier Ford,

Subject: *A Nation-Building Case for a 2+1 Highway for enhanced east-west Canadian trade*

in Alignment with Prime Minister Carney's Five Criteria

Purpose

This briefing presents a compelling case for federal investment in upgrading Northern Ontario's Highway 11 and Highway 17, utilizing **the proven 2+1 highway model.** Supported by evidence in infrastructure policy, safety, economic performance, and national security, the proposal aligns directly with the **five nation-building criteria** set out by Prime Minister Carney under the ***Building Canada Act*.**

We propose a two-phase approach:

- **Phase 1**
  - Construct 2+1 on **Highway 11 segments from North Bay to Cochrane**
  - Construct 2+1 on **Highway 17 from Renfrew to Sudbury**

- **Phase 2**
  - Extend the 2+1 **configuration from Cochrane to Nipigon on Highway 11**
  - Construct the 2+1 **configuration from Thunder Bay to Kenora on Highway 11 and 17**
  - Construct 2+1 on **Highway 17 from Sault Ste. Marie to Sudbury**

This initiative is far more than a regional infrastructure upgrade—it is a nation-building investment. It will strengthen Canada's internal connectivity, improve transportation resilience, and contribute to long-term economic growth, safety, and sovereignty.

Background

With the **Building Canada Act** in place, the Government of Canada is proceeding with consultations with provinces, territories and Indigenous rights-holders to determine the initial list of national interest projects. This proposal presents a project deemed of national interest.

The **Building Canada Act** focuses on creating a unified Canadian economy that promotes enhanced trade between the east and west within Canada. It also focuses on the development of major nation-building projects that will likely involve the transportation of large industrial materials for building. With a vast land area and diverse geography, an efficient transportation network is crucial for connectivity and facilitating the movement of materials.

While air and rail form part of Canada's transportation network, **highways and trucking are the backbone of Canada's transportation system**, connecting major cities, towns and rural communities. Trucking companies and drivers rely on governments to ensure a well- connected transportation network, including highways, major routes, border crossings, and ports, for efficient and safe operations. In turn, knowing the most efficient and safe highways and routes helps truckers save time, fuel, and operational costs.

The Trans-Canada Highway itself—of which Highways 17 and 11 are a vital part—is the **longest continuous national highway in the world**, connecting all ten provinces and three territories. During the Great Depression, the federal government funded the highway's early development as a job-creation initiative and a strategic investment in national cohesion. Over $19 million was allocated to the provinces to construct a continuous road, enabling Canadians to travel across the Dominion without entering the United States. **That same nation-building spirit is now needed once again in Northern Ontario.**

Proposal

Except for Newfoundland, Prince Edward Island, and Ontario, most of the routes used by truckers crossing Canada are four-lane highways. In Ontario, truckers heading east from Manitoba or west from Quebec can choose to cross the province via Highway 17, the Trans-Canada Highway, or Highway 11, and what is now known as the **Northern Trans- Canada Route.** Truckers travelling from Toronto to western Canada can choose to take either 1) Highway 69 to Highway 17, then join the **Northern Route** of Highway 11 via West Nipissing and King's Highway 64, or 2) Highway 11 to North Bay, then the **Northern Route**. Almost all sections of Highways 17 and 11 between the Manitoba border and Renfrew in eastern Ontario are two lanes, except for ongoing highway

twinning projects near Nipigon and west of Thunder Bay, as well as a small, complete section east of Sault Ste. Marie. A small section of twinning has also been completed at Arnprior.

With Ontario being Canada's busiest province for truck traffic, these vital highways, which are linked to much of the country's economic activity, need to be considered for continued expansion beyond their existing two-lane profile. From their early days, they have formed part of Canada's **critical national corridor,** from playing a foundational role in connecting Canada's frontier communities to enable economic development and assert national sovereignty across the North. Unfortunately, road safety and infrastructure conditions in northern Ontario are deteriorating, according to the Ontario Trucking Association. Their primary concern is the danger of passing other vehicles. In turn, the Truckers for Safer Highways association recently stated: "People and truckers are dying on these highways!" That is why the Federation of Northern Municipalities, an organization representing 110 cities, towns and municipalities, has been a consistent and vocal advocate for the adoption of the 2+1 highway model in Northern Ontario. This cost-effective, safety-enhancing design has proven successful in many countries, including Sweden, Finland, and Australia. A 2+1 highway expands on a 2-lane road by implementing continuously alternating passing lanes and separates opposing directions of traffic with a crash-rated median barrier, resulting in safety outcomes that are equal to fully twinned highways.

The Government of Ontario is responding and has announced two pivotal initiatives that mark a turning point for Highway 11, offering a clear opportunity for federal collaboration. First, a **pilot project** is scheduled to commence in 2026 on a 2+1 highway segment between **North Bay and Temagami**. Second, the province committed to extending the 2+1 configuration further north, from **Temiskaming Shores to Cochrane**. These two segments lay the groundwork for a scalable, long-term corridor strategy—a shared infrastructure vision well-suited to a federal-provincial nation-building partnership that would see a phased approach to northern Ontario's highway development.

Data from Statistics Canada (see Appendix A) highlights that a five-year average from 2013 to 2017, over 925,000 truck shipments were made between Western Canada and the Toronto/Montreal region via two-lane highways in Northern Ontario. By comparison, 960,005 between Toronto and Montréal, 206,574 between Toronto and Hamilton and 96,607 between Toronto and Windsor — routes served by four-lane highways. Put simply, there is as much transport traffic on Highway 17 and 11 as on the Highway 401 corridor—but it is forced to spread over narrower, less safe roads.

Priority should be given to Highway 11, as it offers a **preferred westward route** for commercial carriers. Compared to Highway 17, it is less hilly reducing fuel consumption and is not subject to frequent closures caused by Lake Superior's weather systems. In short, Highway 11 is more reliable and increasingly indispensable to national logistics and supply chains. Highway 11 will also be critical to the rapidly expanding mining and agriculture sectors in the north that depend on a safe and efficient transportation corridor.

Ministry of Transportation **Annual Average Daily Traffic (AADT)** volumes from 2021 confirm this importance:

- **Near Temiskaming Shores**: 7,800
- **Near Englehart**: 6,100
- **Between Kirkland Lake and Cochrane**: 3,200 to 5,500

These figures **meet or exceed international thresholds** for 2+1 highway justification. In fact, Ontario's Ministry of Transportation and Swedish transport authorities both find 2+1 highways are effective and safe at volumes of up to **18,000–20,000 AADT**, which is well above the current corridor levels of 3,200–7,800. This places Highway 11 within the model's ideal "sweet spot"—not only today, but for decades to come.

Moreover, these traffic counts were gathered during the COVID-19 pandemic, when private vehicle use was depressed. Actual normalized volumes are likely even higher.

Despite this high usage and strategic importance, Highway 11 faces challenges stemming from decades of underinvestment. These include:

- **Substandard Road Geometry**
- **Insufficient passing opportunities**
- **Above-average collision and fatality rates**
- **Regular closures due to weather and accidents**

These weaknesses not only endanger lives but also **disrupt freight movement**, **delay goods**, and **increase costs** for industries that depend on timely delivery. The **2+1 model, featuring a crash-rated median barrier and alternating passing lanes every few kilometres, significantly improves safety and traffic flow at a substantially reduced cost compared to** traditional four-lane twinning. This makes it the ideal design for long rural corridors with steady but moderate traffic, such as Highway 11.

Alignment with Prime Minister Carney's Five Nation-Building Criteria

1. **Strengthen Canada's Autonomy, Resilience, and Security**

- **Strategic Defence Logistics**: Highways 17 and 11 support access to key military and NORAD infrastructure, including CFB North Bay. It also offers critical redundancy should either highway become compromised.
- **Nuclear Waste Transport**: The Nuclear Waste Management Organization has identified these highways for the secure transport of used nuclear reactor rods to a planned long-term storage site in Northwestern Ontario. Enhanced road safety is essential.
- **Emergency and Climate Resilience**: These roads play a vital role in wildfire evacuations and emergency response functions that will only grow more urgent with climate change.
- **Critical Minerals Access**: As Canada builds out its critical minerals sector, Highways 17 and 11 are essential for transporting the tools, supplies, and workforce needed to unlock Northern resource potential.

2. **Deliver Economic Benefits and Support Growth**

- **Economic Resilience and Supply Chain Reliability**: Highways 17 and 11 are a lifeline for national industries such as mining, forestry, agriculture, and manufacturing. Collisions and closures in this corridor disrupt supply chains, delay shipments, and raise costs—undermining productivity and competitiveness. A safer, more reliable route will protect against these losses and help sustain Canada's industrial and export performance, particularly as interprovincial trade barriers ease and east-west commercial traffic increases.
- **Workforce Access and Regional Efficiency:** Improved traffic flow enhances access for workers, goods, and services, strengthening regional economies and making it easier for businesses to attract and retain talent.
- **Job Creation and Indigenous Participation:** Construction and long-term maintenance will create employment opportunities, with strong potential for Indigenous training, contracting, and equity partnerships.
- **Tourism and Local Business Vitality:** As the primary transportation artery for dozens of rural communities, Highways 17 and 11 support tourism, retail, and service sectors. Safer, faster routes help keep these towns economically viable and socially connected.
- **High Return on Investment:** According to the Northern Policy Institute, the proposed 2+1 pilot for Highway 11 delivers a benefit-cost ratio of **1.0 at 20 years**, rising to **3.6 at 60 years**—clear evidence of enduring value.

3. **High Likelihood of Successful Execution**

- **Shovel-Ready Projects**: Ontario's North Bay–Temagami pilot is fully designed and poised to go to tender
- **Provincial Commitment Already Secured**: The province has also announced plans to extend the 2+1 model northward between Temiskaming Shores and Cochrane.
- **Proven Design Model**: The 2+1 design has achieved fatality reductions of up to 76% in countries like Sweden, Finland, and Australia. It offers a practical model for safe, efficient travel across long rural corridors. Ontario's projects benefit from this international evidence.
- **Faster Cheaper Delivery**: By leveraging existing roadbeds, 2+1 roads require less land acquisition and construction time, avoid delays from environmental permitting, and can be implemented in phases. Ontario's own pilot designs incorporate global best practices from around the world.
- **Expandable by Design**: 2+1 highways can be converted to 2+2 highways in the future when traffic volumes warrant it, making 2+1 roads a flexible and cost- efficient steppingstone, ideal for future-proofing national transportation infrastructure.

4. **Advance the Interests of Indigenous Peoples**

- **Early and Ongoing Engagement:** Highways 17 and 11 intersect the traditional territories of several Indigenous Nations. Their early and ongoing involvement ensures meaningful participation and long-term benefits.
- **Pathways to Economic Reconciliation**: Indigenous-led training, employment, and equity stakes can be prioritized into project delivery, creating generational value. With designs that are modular, the Proposal also supports phased contracting models.
- **Improved Safety for Remote Access**: Both Highways are a lifeline for many Indigenous communities, enabling access to healthcare, food, education, and evacuation routes. Safer highways are a matter of equity.

5. **Contribute to Clean Growth and Climate Objectives**

- **Lower Emissions from Freight**: Improved traffic flow reduces idling, braking, and congestion, directly cutting greenhouse gas emissions. Infrastructure for electric vehicle (EV) charging can be integrated into the design.
- **Sustainable Construction Practices**: Ontario's design process is already integrating lower-emission materials and recycled aggregates to help Canada reach its climate goals.
- **Reduced Environmental Footprint**: Compared to full twinning, 2+1 highways use less land, preserve wildlife corridors, and prevent overbuilding—balancing transportation needs with environmental stewardship.

Conclusion

Transforming the Trans-Canada's Highway 17 and its Highway 11 Northern Route into 2+1 corridors is not simply a matter of regional equity—it is a strategic investment in Canada's future. It safeguards our autonomy, strengthens our supply chains, advances reconciliation, and supports economic growth—while reinforcing the vital national bond between northern and southern Canada. FONOM believes this project reflects the values and vision of a confident, resilient country—one that invites its northern regions to be equal partners in prosperity. **We now call on the provincial and federal government to build a Trans-Canada Highway worthy of our national ambitions—modern, safe, autonomous, and truly coast-to-coast.**

Sincerely,

Danny Whalen President Federation of Northern Ontario Municipalities

306-665 Oak Street East North Bay, ON P1B 9E5 Tel: (705) 498-9510 Email: fonom.info@gmail.com Website: www.fonom.org

Appendix A

Number of Truck Shipments by Routes Note 1						**# of lanes in Ontario**
	2013	**2014**	**2015**	**2016**	**2017**	
Truck shipments to and from major destinations in western Canada to Toronto and Montreal	1,019,899	927,405	986,136	924,682	767,998 **NOTE: 5 year average 2013 to 2017= 925,224**	2 lanes northern Ontario / 4 lanes southern and eastern segments
Truck shipments to and from Toronto and Montreal	867,321	894,068	1,237,732	916,433	884,474 **Note: 5 year average = 960,005**	4+ lanes
Truck shipments to and from Toronto and Windsor	67,119	100,507	97,640	80,267	142,502 **Note: 5 year average= 97,607**	4+ lanes
Truck shipments to and from Toronto and Hamilton	181,567	191,839	186,954	332,986	139,044 **Note: 5 year average= 206,514**	4+ lanes

Note 1: Statistics Canada. Table 23-10-0142-01 Origin and destination of transported commodities, Canadian Freight Analysis Framework (see Appendix A). Shipments represent the aggregate number of shipments transported.

Ministry of Health

Office of the Deputy Premier
and Minister of Health

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
www.ontario.ca/health

Ministère de la Santé

Bureau du vice-premier ministre
et ministre de la Santé

777, rue Bay, 5e étage
Toronto ON M7A 1N3
Téléphone: 416 327-4300
www.ontario.ca/sante

Ontario

eApprove 72-2024-638

February 5, 2026

René Lapierre
Chair, Board of Health
Sudbury and District Health Unit
1300 Paris Street
Sudbury ON P3E 3A3

Dear René Lapierre:

I am writing with respect to the Board of Health's appointment of Dr. Mustafa Hirji to the position of Medical Officer of Health for the Sudbury and District Health Unit.

I am pleased to approve the appointment of Dr. Hirji as Medical Officer of Health for the Sudbury and District Health Unit.

This approval is granted in accordance with Clause 64(c) of the *Health Protection and Promotion Act.*

Sincerely,

Sylvia Jones
Deputy Premier and Minister of Health

c: Dr. Mustafa Hirji, Medical Officer of Health, Sudbury and District Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health and Assistant Deputy Minister
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health, Public Health
France Gélinas, MPP, Nickel Belt
Jamie West, MPP, Sudbury
Bill Rosenberg, MPP, Algoma-Manitoulin

Ministry of Health

Office of the Deputy Premier
and Minister of Health

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
www.ontario.ca/health

Ministère de la Santé

Bureau du vice-premier ministre
et ministre de la Santé

777, rue Bay, 5e étage
Toronto ON M7A 1N3
Téléphone: 416 327-4300
www.ontario.ca/sante

Ontario

eApprove 72-2024-752

February 5, 2026

René Lapierre
Chair, Board of Health
Sudbury and District Health Unit
1300 Paris Street
Sudbury ON P3E 3A3

Dear René Lapierre:

I am writing with respect to the Board of Health's appointment of Dr. Emily Groot to the position of Associate Medical Officer of Health for the Sudbury and District Health Unit.

I am pleased to approve the appointment of Dr. Emily Groot as Associate Medical Officer of Health for the Sudbury and District Health Unit.

This approval is granted in accordance with Clause 64(c) of the *Health Protection and Promotion Act.*

Sincerely,

Sylvia Jones
Deputy Premier and Minister of Health

c: Dr. Mustafa Hirji, Medical Officer of Health (A), Sudbury and District Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health and Assistant Deputy Minister
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health, Public Health
France Gélinas, MPP, Nickel Belt
Jamie West, MPP, Sudbury
Bill Rosenberg, MPP, Algoma-Manitoulin

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approve the consent agenda as distributed.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M.M. Hirji, Medical Officer of Health/Chief Executive Officer

Date: February 12, 2026

Re: Follow-up to Inquiry on 2026–2028 Risk Management Plan Regarding High Risk Items with Minimal Mitigation from Controls

☒ For Information ☐ For Discussion ☐ For a Decision

Issue:

Risk management enables an organization to achieve better outcomes by helping to navigate and build resilience to threats that could disrupt operations, while clarifying strategic opportunities.

On January 15, 2026, the Board of Health approved the 2026-2028 risk management plan and requested more details related to the risks which are rated "red" (highest risk) for both inherent and residual risk ratings. The following provides challenges affecting the plausibility of controls substantially reducing those risk ratings.

Recommended Action:

That the Board of Health for Public Health Sudbury & Districts:

1. **Receive for Information** further details on the six highest "red" risks *(inherent and residual risk ratings)*.

Background:

Across the six risks highlighted in this briefing note, Public Health Sudbury & Districts (Public Health) has implemented all feasible controls within its mandate and budget—strengthening internal processes, enhancing communications, engaging partners, advocating to other levels of government, and improving equity-focused practices. Despite these efforts, the residual risk ratings are only minimally changed and remain in the same high risk "red" category because the primary drivers of these risks stem from large-scale systemic, structural, or external forces that lie well beyond Public Health's authority or capacity to influence. Whether rooted in national and international economic pressures, province-wide service delivery gaps, structural racism, jurisdictional ambiguities, widespread misinformation, or geopolitical factors such as tariffs, these challenges cannot be resolved through local operational controls alone. Public Health does not have the fiscal resources, legislative authority, or political influence required to

alter these broader environments. As a result, while the organization continues to take actions within its control to mitigate what it can, the remaining levels of risk reflect conditions that Public Health must navigate but cannot change. These risks are documented within the Risk Management Plan to provide transparency on the risks that will affect the organization in the next three years.

Specific Details on the Six High "Red" Risks

Financial Risk 1.1: Inability to fund levels of programming desired by the community or mandated by the provincial government, engage in fulsome community engagement, maintain reputation adequately, nor leverage strategic opportunities due to reduced availability of revenue.

Inherent risk rating: L5 I5 / Residual risk rating: L4 I5

Challenge to further mitigate:

Public Health continues to implement controls to mitigate this risk by sharpening outcomes-based advocacy to government, pursuing alternate funding sources such as Primary Care Expansion and grant funding, investing in technology to realize operational efficiencies, and maintaining financial reserves at or above the Ministry of Health's recommended 7.5-week threshold to support emergency needs and strategic opportunities.

However, the residual risk rating cannot be reduced further because the solution is a change in position of another level of government, the provincial government. Public Health has very limited influence on provincial decision-making, being from a region for the province with relatively little political sway with the current government (e.g. the region is not a population nor economic powerhouse, the region is largely represented by opposition MPs), and a sector that is not popular with the current government. Moreover, advocating for increased funding runs counter to the province's overarching objective of restraining public-sector spending. Organizations that successfully shift provincial funding decisions typically do so by investing millions of dollars in lobbying or broad public-opinion campaigns—Public Health does not possess those sorts of resources, and that level of political lobbying would not be an appropriate use of public funds as a public agency.

The only alternative to influencing the provincial government would be for Board members to decide to further increase municipal levies. This would be within local control and could plausibly be done. However, municipalities are struggling to control levy increases and have limited willingness to allocate additional funding to public health. It is the Board's current position and direction to staff that municipal levy increases for Public Health should be modest.

Public Health does not have the tools, authority, or financial capacity to meaningfully impact this risk further through influencing the provincial government. And it is the position of the Board that large increase of funding should not be sought through municipal levies. Therefore, the controls that remain are being pursued, but they leave the residual risk rating only minimally changed.

Knowledge risk 4.1: Erosion of public trust of Public Health messaging, misinterpretation of information, and reputational damage due to communication practices that are not successful at breaking through a busy and misinformation-filled information environment.

Inherent risk rating: L5 I3 / Residual risk rating L4 I3

Challenge to further mitigate:

Public Health is implementing meaningful controls—expanding communication capacity, shifting toward more agile and engaging messaging approaches, broadening communication channels, and increasing the visibility of trusted spokespeople—to mitigate the erosion of public trust, misinterpretation of information, and reputational harm. However, the residual risk cannot be lowered further as the dominant drivers of this risk lie well beyond Public Health's sphere of influence.

Public trust in institutions, the polarization of public discourse, and the overwhelming volume of misinformation circulating across digital platforms are national and global issues and cannot be corrected through local communication strategies alone. Competing successfully in an environment where misinformation is produced at industrial scale would require, at minimum, sustained, multimillion-dollar investments in branding, marketing, artificial intelligence–driven content production, and public persuasion—resources available to national organizations, but far outside the fiscal capacity, mandate, or appropriateness of a local public health agency. Misinformation can likely only be effectively combatted through dedicated engagement by national governments across the globe, including with major changes to regulation of social media and other information media.

While Public Health continues to strengthen the tools within its control to mitigate the impact of misinformation where it can, the residual level of risk reflects systemic information ecosystem challenges that we must navigate but cannot fundamentally reshape.

Service Delivery / Operational Risk 7.1: Lack of available services, reduced continuity of care, and poorer health for Public Health clients due to the absence of a sector taking accountability to lead key aspects of clinical care *(specific to clinical areas that overlap with primary care mandates).*

Inherent risk rating: L5 I5 / Residual Risk Rating: L5 I4

Challenge to further mitigate:

Public Health has taken all reasonable actions within its control such as actively participating in the Ontario Health Team's Primary Care Council and exploring opportunities to leverage primary care funding mechanisms to expand access for Public Health's clients.

However, the underlying challenge cannot be further mitigated because Public Health does not have authority over, nor funding to provide, primary care. Primary care partners are currently overwhelmed by the pressures of growing health challenges, and therefore have limited ability to take on additional clinical work, which impacts Public Health clients. As a result, despite all feasible internal efforts, the residual risk remains high because the core drivers—lack of authority or funding for Public Health to

deliver primary care services relevant to our mandate, the absence of primary care governance in Ontario, and primary care capacity constraints—lie outside Public Health's control.

Political risk 9.3: Inequitable delivery of Public Health services and reduced trust in public health systems due to jurisdictional ambiguity between federal, provincial, and First Nation authorities regarding service delivery to First Nation communities.

Inherent Risk Rating L5 I4 / Residual Risk Rating L5 I3

Challenge to further mitigate:

Public Health continues to engage directly with First Nation communities to offer support where desired and to advocate to federal and provincial authorities to address longstanding jurisdictional gaps in service delivery.

At this point, we cannot reduce the remaining risk any further because the main issue—the unclear responsibilities between the federal and provincial governments, and how they work with First Nations governments—is a long-standing structural problem that is beyond the control of local Public Health.

Over the past nine months, Public Health has reached out many times to both levels of government to push for action, but there has been very little progress. Responses have been slow, and the larger issues remain unresolved. Public Health does not have the authority or influence to make these governments clarify their roles or address these inequities, and we do not have the tools to shift political priorities so that this becomes something government works on more quickly.

Even with full cooperation from all parties, making meaningful change would still be extremely challenging because these issues are tied to the impacts of more than 500 years of colonialism. Progress, if it happens, will take a long time.

As a result, even with all feasible controls in place, the residual risk remains elevated because the underlying drivers lie beyond Public Health's control.

Political risk 9.4: Increased costs, impacted quality and equity of care, and poorer health outcomes for Public Health clients due to imposition of tariffs on imported items which further strain budgets, and reduces access to necessities of daily living, like nutritious food, which particularly affects vulnerable populations.

Inherent risk rating L4 I3 / Residual risk rating L4 I3

Challenge to further mitigate:

Public Health is implementing all feasible controls within its mandate, including advocating for tariff exemptions on essential food imports, strategically timing organizational purchases to avoid tariff impacts where possible, and exploring non-US suppliers for tariff-affected goods. However, the residual risk cannot be further reduced because the primary driver—the imposition of US tariffs on imported goods—is entirely outside Public Health's influence.

Public Health has no role, authority, or presence in international trade negotiations, where these decisions are made. Even federal and provincial governments, despite their vastly greater jurisdictional power and resources and their prioritizing this issue through 2026, have achieved only mixed success in mitigating tariff impacts. Furthermore, Public Health lacks the financial capacity to offset rising costs by directly subsidizing affected populations or absorbing the increased expenses associated with tariff-driven price inflation.

As a result, while Public Health is taking all reasonable steps available to it, the underlying conditions remain externally determined, leaving the residual risk unchanged, reflective of these uncontrollable geopolitical and economic forces.

Equity risk 14.2: Worsening health inequities and outcomes as well as reduced trust and engagement in the public health system, particularly among marginalized populations, due to systemic racism and barriers that bias to inequitable delivery of Public Health programs and services.

Inherent risk rating L5 I4 / Residual risk rating L4 I3

Challenge to further mitigate:

Public Health has strengthened its internal capacity to address inequities by investing in staff training on cultural competence and anti-racism, integrating mandatory health equity impact assessments into program planning, deepening structured community engagement with equity-seeking populations, and ensuring accessible, culturally safe channels for feedback and complaints. These measures meaningfully improve how programs are delivered and how Public Health engages with marginalized communities.

However, the residual risk cannot be lowered further because the primary drivers—systemic racism, discrimination, and societal biases—are pervasive, Canada-wide and world-wide issues far beyond the influence of any single public health unit. Public Health does not have the tools to meaningfully shift national public attitudes, societal norms, or long-standing structural inequities. While Public Health continues to strengthen its practices and collaborate with local partners to improve equity in service delivery, these efforts can only mitigate a portion of the overall risk. The remaining risk reflects deep, systemic forces that exceed Public Health's scope to change, even with all feasible internal controls in place.

Financial Implications:
There are no financial implications to receiving this briefing note. Should the Board of Health wish to invest in meaningful mitigation of any of these 6 risks, the financial investment in future budgets would require substantially increasing municipal contributions to Public Health which is not recommended as appropriate or aligned with past Board of Health direction.

Strategic Priority:
#3 – Excellence in public health practice

Author:
Krista Galic, Manager of Quality and Monitoring, Corporate Services

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M. Mustafa Hirji, Medical Officer of Health and Chief Executive Officer

Date: February 12, 2026

Re: Healthy Smiles Ontario fee schedule and the impacts it has on access to dental care for children and youth

☐ For Information ☒ For Discussion ☒ For a Decision

Issue:

Children and youth face significant barriers in accessing the Healthy Smiles Ontario (HSO) program. The primary barrier stems from a fee schedule that reimburses dentists well below the 2026 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners. Consequently, provider participation in HSO is lower than otherwise.

Delayed or untreated tooth decay/infections can be painful, affect concentration/school performance, disrupt eating and sleeping patterns, affect permanent tooth structures, and lead to life threatening conditions[1]. Dental caries are also a leading cause of pediatric dental surgery and the most common reason children require day surgery under general anesthesia [1,2]. These impacts are compounded for families facing social and structural barriers such as low income, limited access to preventive care, residence in rural or Indigenous communities, and newcomer status, highlighting the need for early prevention and detection to improve health outcomes and reduce strain on the healthcare system[2,3,4,6].

Recommended Action:

That the Board of Health advocates to the Ministry of Health to increase reimbursement rates outlined in the *Healthy Smiles Ontario (HSO) Schedule of Dental Services and Fees* for dentist providers, aligning them more closely with the 2026 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners. This adjustment is essential to encourage provider participation and improve access to care for the children in greatest need.

Advocacy can proceed through two avenues:

1. **Cross-Agency Collaboration**
   Barriers utilizing HSO locally are echoed across Ontario, underscoring a province-wide challenge that demands a unified voice; partnering with other local public health agencies (LPHAs) to amplify the call for improved HSO fee scheduling is critical to strengthen the case

2024–2028 Strategic Priorities

1. Equal opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

for increased funding. For instance, The Ontario Association of Public Health Dentistry (OAPHD) could potentially provide a venue for engaging other LPHAs in provincial advocacy work. While more time consuming, this approach has the potential to be more impactful and aligns with the strategic priority to foster impactful partnerships.

2. Agency-Level Advocacy
   Advocating independently for an increased HSO fee schedule would allow us to share the barriers experienced by our community. While this may be less impactful than a coordinated effort, it still provides an opportunity to highlight local needs.

Alternative Actions:
Remain status quo and utilize the referral list we have created to strive for clients to receive care promptly, and advocate to the Ministry of Health only if dental offices stop allowing their names to be shared.

Background:
Healthy Smiles Ontario Program:
Healthy Smiles Ontario (HSO) is a provincial dental program that provides preventive, routine, and emergency dental services for children and youth 17 years old and under from Ontario households who qualify based on income eligibility requirements.

Healthy Smiles Ontario Delivery:
Services are predominantly delivered through dental offices across the province with the exception of a few LPHA's that provide services onsite. Acceptance of HSO insurance is at the discretion of individual dental providers. Healthy Smiles Ontario reimburses dental offices in accordance with the *Healthy Smiles Ontario Schedule of Dental Services and Fees for Dentist Providers*. HSO's pay grid for services outlines reimbursement rates that are far below industry standards throughout Ontario resulting in providers being reimbursed at roughly 40 cents on the dollar. Providers are unable to balance bill HSO patients to accommodate this difference.

Canadian Dental Care Plan Program:
The Canadian Dental Care Plan (CDCP) is a federal program designed to make dental care more affordable and accessible for eligible Canadians who have an annual adjusted family net income of less than $90,000 and no access to private dental insurance. This plan provides coverage for preventative, diagnostic, and restorative dental services.

Canadian Dental Care Plan Delivery:
Similarly to HSO, CDCP is accepted at the dental providers' discretion. Additionally, dental providers can balance bill patients using CDCP, meaning they may charge the patient the difference between the reimbursement provided by CDCP and the ODA Suggested Fee Guide amount for a procedure. This can result in unexpected financial burden for families and the possibility that treatment is delayed or not completed.

HSO and the CDCP:
HSO benefits can be coordinated with the CDCP to provide more coverage for the patient and can reduce out-of-pocket costs for dental fees that would not be covered by one program alone. When both plans are used together, the CDCP is the primary payer and HSO is the secondary payer. It is important to note, if a patient uses both the CDCP and HSO together, the dental providers are not allowed to balance bill the patient.

Local Context of HSO acceptance by dental providers:
Locally, dental services are provided through dental offices that accept HSO, as our location at 1300 Paris Street does not have a clinic room equipped for dental treatment. The clinic space at 10 Elm Street is designated for the Ontario Seniors Dental Care Program, where we provide comprehensive services such as dental cleanings, fillings, root canal treatments, and extractions. We currently have a dentist working at this location 2.5 days per week. At 1300 Paris Street, we only offer dental cleaning appointments for children and youth enrolled in the preventive-only stream of the HSO program.

Historically, we maintained an HSO referral list that allowed us to direct clients to dental providers for treatment. Over time, more and more dental offices informed us that they were no longer able to accept referrals of new HSO clients. Eventually, no dental offices remained on the referral list, and so we had nowhere to send clients anymore. When HSO clients called seeking assistance in finding a dentist, we instead had to advise them to try to call offices themselves and hope they would be seen through direct appeal. The HSO website nonetheless continued to advise clients to contact their local public health agency for help, resulting in confusion for clients.

More recently, clients have begun reporting that dental offices are requiring them to have the CDCP coverage in addition to HSO to be seen, or that they must pay out of pocket in part or in whole to be seen. One significant barrier is that not all families qualify for the CDCP, particularly newcomers to Canada, those who have not filed income taxes, or those with even minimal private dental insurance.

To better understand local provider participation and to rebuild the referral list we previously maintained, we conducted a survey this past summer with local dentists. The purpose of this survey was to determine whether they accept HSO on its own, or only when coordinated with the CDCP; we also asked whether they were willing to be included on a referral list. This work aligns with our responsibilities under the Oral Health Protocol, including providing navigation support and helping clients establish dental homes.

Findings:
For this survey, a total of 59 dental offices were contacted, and responses were received from 56 of them. Two offices did not respond, despite multiple follow-up attempts, and one dentist had retired. Among the responding offices, 14 dentists (25%) reported that they accept HSO as the primary coverage without supplementation, and confirmed that we may include them on the referral list. These providers

are prioritized for families who have HSO only and are not eligible for the CDCP. An additional 13 dentists (23%) indicated that they accept only HSO and the CDCP combined coverage and we may include them on the referral list. All remaining offices surveyed (52%) indicated that they are not accepting HSO at this time and therefore cannot receive referrals.

Financial Implications:
None

IT team and IT infrastructure implications:
None

Ontario Public Health Standard:
School Health Standard, requirement 6 in accordance with the Oral Health Protocol, 2018

Strategic Priority:
1. Equal opportunities for health
2. Impactful relationships

Authors:
Stephanie Meyer, Oral Health, Program Manager
Joseph Gedey, Oral Health, Health Promoter
Jodi Maki, Medical Informatics Specialist

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HEALTHY SMILES ONTARIO FEE SCHEDULE AND THE IMPACTS IT HAS ON ACCESS TO DENTAL CARE FOR CHILDREN AND YOUTH

MOTION:

WHEREAS children and youth in Ontario face significant barriers in accessing dental care through the Healthy Smiles Ontario (HSO) program due to a fee-schedule that result in reduced provider participation; and

WHEREAS acceptance of HSO is at the discretion of individual dental providers, and many offices choose not to participate because reimbursement rates under the HSO Schedule of Dental Services and Fees are substantially lower than the 2025 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners; and

WHEREAS delayed or untreated dental issues can lead to pain, impaired concentration and school performance, disrupted eating and sleeping patterns, permanent tooth damage, the need for surgery under anesthesia, and in the most severe cases, life-threatening conditions; and

WHEREAS early prevention and detection significantly improve health outcomes and reduce strain on the healthcare system;

THEREFORE BE IT RESOLVED THAT the Board of Health requests that the Ministry of Health increase reimbursement rates outlined in the Healthy Smiles Ontario (HSO) Schedule of Dental Services and Fees for dentist providers, so that they align with the 2026 Ontario Dental Association (ODA) Suggested Fee Guide for General Practitioners, in order to encourage provider participation in HSO and improve access to care for children and youth; and

FURTHER THAT the Board directs the Medical Officer of Health to engage in both cross-agency collaboration with other local public health agencies and agency-level advocacy to strengthen the case for improved HSO fee scheduling.

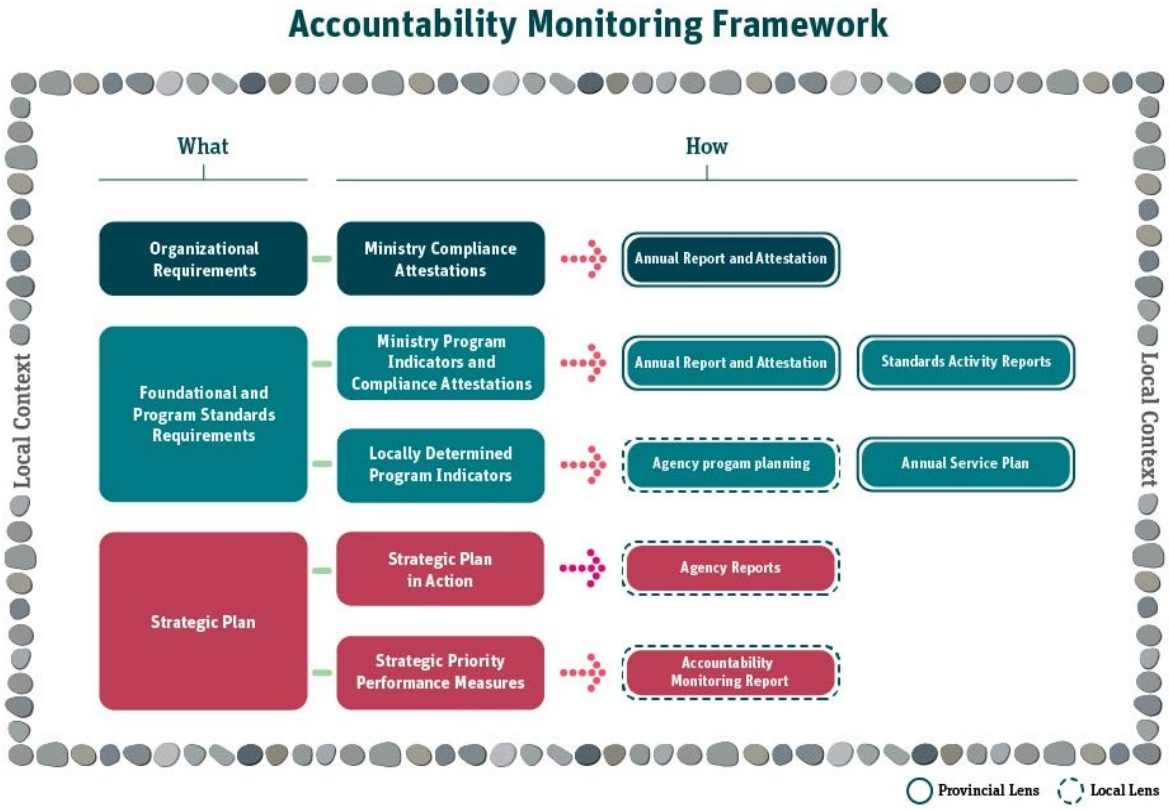
2025 Accountability Monitoring Report

Public Health Sudbury & Districts
2025

Public Health
Santé publique
SUDBURY & DISTRICTS

Contents

The *2024–2028 Accountability Monitoring Plan* provides a framework for monitoring and reporting on legal, funding, and program requirements. It is also a tool to demonstrate a commitment to transparency. This report includes three main monitoring and reporting categories to collectively demonstrate how we fulfill provincial mandates and local commitments. These include Organizational Requirements, Foundational and Program Standard Requirements, and the Strategic Plan.



Organizational Requirements

Public Health monitors or reports on the Organizational Requirements pertaining to the following four domains of accountability in the *Ontario Public Health Standards (OPHS)*: delivery of programs and services, fiduciary requirements, good governance and management practices, and public health practice. In addition, Public Health monitors other requirements that the OPHS identifies as common to all domains. Accountability for the Organizational Requirements is demonstrated through the annual report and attestation (ARA) that boards of health submit annually to the Ministry of Health (Ministry).

Ministry Compliance Attestations

The board of health submitted the 2024 Annual Report and Attestation to the Ministry of Health in June 2025, reflecting a reporting period from January to December 2024. Public

Health Sudbury & Districts was compliant with 61 of 62 requirements. The reason for non-compliance in one of the requirements was due to a technological limitation of our software.

Foundational and Program Standards Requirements

Public Health monitors requirements for the Foundational Standards and Program Standards through Ministry program indicators and compliance attestations as well as locally determined program indicators. The annual report and attestation (ARA) to the Ministry includes attestation statements to demonstrate program compliance and output data for designated indicators. The standard activity reports (SAR), also used to report on Ministry program indicators, include interim information on select program topics as requested. Locally determined program indicators are outlined in the agency's annual service plan and budget submission (ASP) and reported on as required through the ARA. Program indicators are also incorporated into local plans through a systematic program planning process and monitored in accordance with agency needs.

Ministry Program Indicators and Compliance Attestations

A summary of 2025 program indicators and compliance with the 2025 attestation statements will be provided in the annual 2026 Accountability Monitoring report, following submission to the Ministry of Health in April 2026.

Locally Determined Program Indicators

Locally determined program indicators will be reported in the annual 2026 Accountability Monitoring Report.

Strategic Plan

The *2024–2028 Strategic Plan* includes four strategic priorities: equal opportunities for health, impactful relationships, excellence in public health practice, and healthy and resilient workforce. The strategic priorities are guided by our values of humility, trust, and respect, and help Public Health accomplish its vision and mission. Public Health measures performance and progress as it relates to the *2024–2028 Strategic Plan* and the implementation of the four strategic priorities through ongoing reporting and strategic priority performance measures.

Process for connecting all work back to the Strategic Plan

Reporting on the implementation of the Strategic Plan includes providing highlights within agency reports and stories that demonstrate plan in action. Staff are encouraged to intentionally connect all work back to the Strategic Plan. Monthly board reports and program plans included connections back to the strategic priorities and values as relevant. In 2025, the *Public Health in Focus* newsletter also featured narratives in alignment with the strategic priorities.

Strategic priority performance measures

Reporting on the Strategic Plan also includes performance measures for each strategic priority, for a total of 15 performance measures. Strategic priority performance measures illustrate diverse approaches and practices to demonstrate accountability for the strategic priorities. For the 2025 report, program staff and managers reported relevant data for the strategic priority performance measures based on existing tracking and evaluation mechanisms. Information was then collated in a centralized data collection tool to inform this report.

Alignment with the 2026-2028 Risk Management Plan

Public Health has included a dedicated section in this Accountability Monitoring Report to demonstrate the alignment between the agency's Strategic Priorities and its Risk Management Plan. The Strategic Plan articulates *what* the organization is working to achieve over the 2024–2028 period, while the Risk Management Plan identifies the key organizational risks that could affect our ability to deliver on those priorities as well as our broader mandate.

Note: Since performance measures were only approved by the Board of Health in September 2024, there was no standardized approach for data collection until late 2024; therefore, the criteria for qualifying submissions were only created in 2025. As a result, some performance measures are reported as N/A for 2024 due to no longer being comparable to the submissions and data in 2025. The new criteria places a stronger emphasis on demonstrating the outcome and impact of each initiative or activity, ensuring that submissions reflect not just what was done, but the meaningful results achieved.

Strategic Priority 1: Equal opportunities for health

Performance measure	2024	2025
1.1 Number of advocacy initiatives that support an increased understanding of health equity	N/A	1
1.2 Number of programs and services for which equity and diversity was improved as a result of the use of health equity assessments	2	1
1.3 Number of initiatives where the voices or perspectives of equity-deserving populations informed the development or delivery of activities that are Public Health-led or led in partnership	6	9
1.4. Qualitative description of activities that support advocacy and partnerships to improve self-determined Indigenous health	**Highlighted activity:** In 2024, Public Health invested in re-establishing relationships with five First Nation communities to provide oral health screenings in schools.	**Highlighted activity:** Public Health partnered with Wahnapitae First Nation and Indigenous Services Canada to plan for new ways to conduct the Diseases of Public Health Significance follow up investigations for clients who reside on Wahnapitae First Nation territory. Through this partnership and with support from Chief and Council, Public Health now follows-up directly with residents of Wahnapitae First Nation instead of referring to Indigenous Services Canada.

Explanatory notes:

1.1 Number of advocacy initiatives that support an increased understanding of health equity

A total of one advocacy initiative supported an increased understanding of health equity. Advocacy initiatives include a comprehensive approach with multiple steps and activities prioritizing coordinated action to inform system change and improve health outcomes. For example, advocacy initiatives generally include multi-part approaches with multiple activities, such as presentations to key stakeholders and decision makers, engagement in policy development, municipal plan reviews, letters of support to government, motions to the Board of Health or other governing bodies or sharing of evidence with a Public Health perspective. The advocacy initiative for 2025 was a multi-part advocacy approach for the Community Drug Strategy, including presentations, a public report, media requests and written articles, call out for participation of an advisory committee, naloxone training, and participation in Indigenous Public Health's Fall Harvest Feast event.

1.2 Number of programs and services for which equity and diversity was improved as a result of the use of health equity assessments

One program was improved as a result of the use of health equity assessments. The improvement was the offering of preventive dental care and dental screening for children in Sudbury East, Mindemoya, and Espanola.

1.3 Number of initiatives where the voices or perspectives of equity-deserving populations informed the development or delivery of activities that are Public Health-led or led in partnership

There were a total of nine initiatives where the voices or perspectives of equity-deserving populations informed the development or delivery of Public Health-led or led in partnership activities. An example is the Communicable Infectious Disease team working with affected communities during the measles outbreak, including priority populations. This partnership supported the development of resources for sharing with the communities. Since this partnership, an agency-wide working group was established that plans to continue to partner with these communities.

1.4 Qualitative description of activities that support advocacy and partnerships to improve self-determined Indigenous health

Public Health supports advocacy and partnerships to improve self-determined Indigenous health. Examples from 2025 include the following:

- Enhancing practice for NOSM University Dietetic Practicum Program: Indigenous Food Sovereignty Project. Staff collaborated with two dietetic learners and two Registered Dietitians from Thunder Bay District Health Unit and North Bay Parry Sound District Health Unit to work on a project to identify and critically appraise

training tools and learning opportunities available to dietetic learners and dietitians. A summary document titled ***Indigenous Food Sovereignty and Dietetics: A Review of Available Training Tools and Learning Opportunities for Dietitians and Dietetic Learners*** (Ontario Dietitians in Public Health) was created and is now available to enhance professional practice of dietitians and other health professionals.

- The Indigenous Public Health team presented to the Board of Health for Public Health Sudbury & Districts in May, June, September, and November to support their learning on self-determined Indigenous health. These sessions are part of the Foundational Obligations to Indigenous Peoples series of the *Unlearning & Undoing White Supremacy and Racism Project* (Unlearning Project), which strengthens awareness and understanding of key guidance documents, including the *United Nations Declaration on the Rights of Indigenous Peoples*, the Missing and Murdered Indigenous Women and Girls Final report and Calls to Justice, the Truth and Reconciliation Commission's Calls to Action, and Treaties. This increased awareness is intended to help the Board of Health apply these directives within their sphere of influence and uphold the inherent rights of Indigenous peoples in all aspects of their work.

Alignment with the 2026-2028 Risk Management Plan

The following risks from the 2026-2028 Risk Management Plan align with the findings from the measures for strategic priority 1, Equal opportunities for health, illustrating potential risks to continued achievement of this strategic priority:

7.1: Lack of available services, reduced continuity of care, and poorer health for Public Health clients due to the absence of a sector taking accountability to lead key aspects of clinical care (specific to clinical areas that overlap with primary care mandates).

7.3: Limited community health impact and failure to meet the population's needs due to the organization not designing nor effectively delivering the right programs and initiatives.

8.2: Disruptions to service delivery and worsening of inequitable health outcomes due to climate change impacts such as heatwaves, poor air quality, and vector-borne diseases, particularly affecting vulnerable populations.

9.1: Disruption to public health programs and misalignment of strategy due to changes in the political system that shift priorities, restructure governance, or alter public health mandates.

14.1: Reduced effectiveness of programs and unmet community needs due to failing at timely adaptation to changing demographics within the community.

14.2: Worsening health inequities and outcomes as well as reduced trust and engagement in the public health system, particularly among marginalized populations, due to systemic racism and barriers that bias to inequitable delivery of Public Health programs and services.

14.3: Reduced community trust and missed opportunities for inclusive engagement due to a workforce that is not reflective of the diversity of the local communities Public Health serves.

Strategic Priority 2: Impactful relationships

Performance measure	2024	2025
2.1 Number of changes made to programs and services that improve the health of the community as a result of working collaboratively with community partners	N/A	4
2.2 Number of partnerships, collaborations, and engagements with Indigenous-led organizations or First Nations that led to joint planning, implementation, and evaluation of programs and services for the Indigenous population	N/A	9
2.3 Number of collaborations with municipalities that impact the health of the community	27	35
2.4 Qualitative narratives or examples of programs or services, delivered in partnership, where activities have moved along the spectrum of engagement	**Highlighted activity:** Public Health partners with the Ontario Naloxone Program, which begins with Public Health providing training to local agencies and results in empowering these agencies to effectively utilize naloxone kits and respond to emergency situations.	**Highlighted activity:** Public Health is collaborating with the City of Greater Sudbury to develop an adverse air quality response plan. Response activities are targeted to address risks for those with lower adaptive capacity to protect themselves, such as people living on low income and those who are unhoused.

Explanatory notes:

2.1 Number of changes made to programs and services that improve the health of the community as a result of working collaboratively with community partners

A total of four changes were made to programs and services that improved the health of the community as a result of collaborating with community partners in 2025. An example of this is the Good Food Market Program that continuously works to improve and make the program more accessible and to better meet community needs. Based on information shared through the Good Food Market 2024 Customer Survey and informal feedback received from communities, the program made four substantial changes for the 2025 season: 1) Improving scheduling to better meet customer needsby increasing the length of time the Market was available and offering it at times to better serve the community; 2) changing produce available for sale to better meet community preferences; 3) moving the St. Charles location to better accommodate more community members; and 4) closing select locations due to low participation.

2.2 Number of partnerships, collaborations, and engagements with Indigenous-led organizations or First Nations that led to joint planning, implementation, and evaluation of programs and services for the Indigenous population

In 2025, a total of nine partnerships, collaborations, and engagements with Indigenous-led organizations or First Nations led to joint planning, implementation, and evaluation of programs and services for Indigenous peoples. This highlights the extent and effectiveness of collaborative activities in ensuring culturally relevant programs and services that address the priorities and needs of the Indigenous population. An example of this is in June 2025, a Public Health dental hygienist who is dedicated to the Indigenous oral health daycare programming conducted a train-the-trainer session at the Wikwemikong Health Centre. The health centre manager, daycare manager, and nine support staff from both locations were trained. The session covered the benefits of fluoride varnish, which is supported by literature to significantly reduce tooth decay in children, and discussed its application for children attending the daycare. In 2025, co-design and planning for dental screening clinics occurred and the screenings have been scheduled for January 2026, with fluoride varnish applications to follow. This training marks the first phase of programming that will continue throughout 2026.

2.3 Number of collaborations with municipalities that impact the health of the community

In 2025, Public Health had a total of 35 collaborations with municipalities that impact the health of local communities. Examples of collaborations with municipalities include the following:

- Planet Youth's Icelandic Prevention Model is underway in Sudbury and the LaCloche area, with Public Health Sudbury & Districts working with a team of partners (including co-leads Shkagamik-Kwe Health Centre and Sudbury District Restorative Justice) to support the project as we adapt this model to the local context. Among these partners are the City of Greater Sudbury and the Manitoulin Sudbury District Social Services Advisory Board who sit on the Steering Committee. Each partner will contribute resources (both financial and in-kind), as well as expertise and

commitment, to ensure the model's successful implementation and its adaptability to the unique needs of the local communities.

- Public Health staff support the City of Greater Sudbury Age-Friendly Community Steering Committee and support the planning and implementation of age-friendly work locally.
- Public Health staff attend annual emergency management meetings in Killarney, Baldwin Township, Espanola, Sables-Spanish Rivers, Assiginack Township, Nairn and Hyman Township, Northeastern and Manitoulin Island and is an active member of the Greater Sudbury Emergency Management Advisory Panel.

2.4 Qualitative narratives or examples of programs or services, delivered in partnership, where activities have moved along the spectrum of engagement

Public Health Sudbury & Districts recognizes that the spectrum of community engagement includes five key phases—informing, consulting, involving, collaborating, and finally empowering—as identified in the *Spectrum of Public Participation* from the International Association for Public Participation (IAP2).

An example where Public Health programming moved along the spectrum of engagement, from collaboration to empower, is a service agreement with The ParkSide Centre. The service agreement created new opportunities for urban pole training, specifically to increase the number of facilitators that can deliver the program and expand programming in local communities. Urban poling is a type of low impact, full-body physical activity that uses walking poles to enhance balance, mobility, and posture, supporting falls prevention and overall wellness for older adults. Part of the service agreement included providing The ParkSide Centre with the funds to organize and provide training to volunteers (primarily older adults). The effort to train older adults in urban poling increases older adults' opportunities for volunteerism or employment, which is one of the pillars of an age-friendly community. With Public Health's assistance, they have now collaborated with the Victorian Order of Nurses (VON) community champion volunteer. VON will now assist The ParkSide Centre in the practical training component of urban poling alongside previously trained urban pole facilitators. Through this program, The ParkSide Centre and VON can now offer urban pole groups to community members without Public Health's direct support.

Alignment with the 2026-2028 Risk Management Plan

The following risks from the 2026-2028 Risk Management Plan align with the findings from the measures for strategic priority 2, Impactful relationships, illustrating potential risks to continued achievement of this strategic priority

9.3: Inequitable delivery of Public Health services and reduced trust in public health systems due to jurisdictional ambiguity between federal, provincial, and First Nation authorities regarding service delivery to First Nation communities.

10.1: Reduced collaboration and engagement, and reduced health outcomes due to failing to demonstrate value among partners and local communities.

Strategic Priority 3: Excellence in public health practice

Performance measure	2024	2025
3.1 Number of improvements made that enhanced client, community, and partner experience as a result of client feedback	Data collection process under development	2
3.2 Number of evidence generating projects where findings result in a change in public health practice	23	16
3.3 Number of upstream health promotion initiatives planned and implemented that have a higher population level or long-lasting impact	N/A	6

Explanatory notes:

3.1 Number of improvements made that enhanced client, community, and partner experience as a result of client feedback

Two improvements were made that enhanced client, community, and partner experience as a result of client feedback in 2025. One improvement was the installation of new audio technology in the Boardroom to enhance sound quality and improve the experience of hybrid Board of Health meetings. The other improvement made to practice was based on feedback received from childcare supervisors that resulted in a more streamlined approach to data collection when uploading information to support Child Care and Early Years Act assessments.

3.2 Number of evidence generating projects where findings result in a change in public health practice

Through 2025, 16 projects were completed and resulted in a change or improvement to public health practice.

Examples of projects completed in 2025 that led to a change in public health practice include: a provincial report on monitoring food affordability and food insecurity, which highlighted evidence-based solutions to address food insecurity; an environmental scan of equity, diversity, inclusion, and accessibility (EDIA) policies in sports to inform local policy development; and a collaborative research project under the leadership of Public Health Ontario to identify indicators and tools to measure the process of building healthy public policy.

Evidence-generating projects include a range of activities such as original research, needs assessments, pilot studies, feasibility assessments, and program evaluations. Each evidence-generating project is unique in terms of planning, resources, duration, and intensity.

3.3 Number of upstream health promotion initiatives planned and implemented that have a higher population level or long-lasting impact

In 2025, a total of six upstream health promotion initiatives that have a higher population level, long-lasting impact were planned and implemented. One example of an upstream initiative underway in 2025 is the local implementation of Planet Youth, led by Shkagamik-Kwe Health Centre and Sudbury District Restorative Justice. Public Health is one of many community partners that have come together to bring a pilot of the model to the Sudbury and LaCloche regions. The five-year partnership with Planet Youth provides Public Health with resources to survey youth about substance use and well-being while building community networks and capacity to create healthier environments for youth to grow up. The four domains for change include family, peers, school, and leisure opportunities, with plans for interventions to be informed by the survey results across these areas. By bolstering protective factors and addressing risk factors we can decrease the likelihood that youth will turn to substances, and support them in their development into resilient, healthy adults.

Alignment with the 2026-2028 Risk Management Plan

The following risks from the 2026-2028 Risk Management Plan align with the findings from the measures for strategic priority 3, Excellence in public health practice, illustrating potential risks to continued achievement of this strategic priority:

2.1: Reduced quality of governance and strategic oversight, and ability to maintain high calibre of governance practices, due to changes to Board of Health membership.

3.3: Delays in project completion, reduced quality of outcomes, and missed opportunities due to not having capacity to manage the multiple concurrent initiatives within the organization.

4.1: Erosion of public trust of Public Health messaging, misinterpretation of information, and reputational damage due to communication practices that are not successful at breaking through a busy and misinformation-filled information environment.

7.2: Missed opportunities, partner dissatisfaction, and failure to adapt to changing environments due to the organization’s slow pace of change and limited agility.

7.3: Limited community health impact and failure to meet the population's needs due to the organization not designing nor effectively delivering the right programs and initiatives.

7.4: Inability to demonstrate impact or drive continuous improvement due to not effectively measuring and evaluating outcomes.

9.2: Decreased public engagement and trust, reduced health outcomes, and challenges in attracting and retaining skilled professionals due to a decline in the reputation of the public health sector driven by misalignment with community values, inconsistent messaging, lack of transparency, and politicization of public health decisions made by governments.

Strategic Priority 4: Healthy and resilient workforce

Performance Measure	2024	2025
4.1a) Number of training and professional development sessions where at least 80% of survey respondents reported an increase of knowledge, skills, abilities, or competence	Data collection process under development	9
4.1b) Number of professional development opportunities that resulted in Indigenous focused content incorporated into programs and services	Data collection process under development	2
4.2 Assessment of quality improvement maturity	Stage 2 of 5: **Emerging***	Stage 3 of 5: **Progressing***
4.3 Number of cross training opportunities available for staff in key emergency response roles that facilitate staff rotation, staff respite, and staff redeployment for surge response	Data collection process under development	8

***The quality improvement (QI) maturity survey tool scores QI through the following stages:**

- Step 1: Beginning (have not adopted formal QI projects)
- Step 2: Emerging (newly adopted QI approaches with limited capacity)

- **Step 3: Progressing (some QI experience but lack of commitment and minimal QI integration)**
- Step 4: Achieving (fairly high levels of QI practice with an eagerness to engage in QI)
- Step 5: Excelling (achieving high levels of QI sophistication and a pervasive culture of QI)

Explanatory notes:

4.1 a) Number of agency-led or coordinated training and professional development sessions where at least 80% of survey respondents reported an increase of knowledge, skills, abilities or competence

In 2025, all staff who completed an agency-led or coordinated training session were asked to complete a survey that measures newly acquired knowledge or confidence in applying the learnings in their work. Of the surveys that were offered, nine surveys demonstrated at least 80% of participants reported an increase of knowledge, skills, abilities, or competence.

4.1 b) Number of agency-led or coordinated professional development opportunities that resulted in Indigenous-focused content incorporated into programs and services

In 2025, two professional development opportunities resulted in Indigenous-focused content being incorporated into programs and services, both related to *The Unlearning & Undoing White Supremacy and Racism Project* (Unlearning Project). These include the Unlearning Club and abbreviated presentations to the Board of Health for Foundational Obligations to Indigenous Peoples series.

- The Unlearning Club is a voluntary 18-month learning journey that explores racism, white supremacy, and colonization as key factors influencing health outcomes. It aims to provide participants with the tools to recognize how anti-Indigenous racism and white supremacy manifest in our daily work, through policies, practices, and processes, and to actively adopt anti-racist strategies to challenge and dismantle these systems.

4.2 Assessment of quality improvement maturity

A quality improvement maturity survey was administered to all staff in November 2025. Ninety-one (91) staff participated in the survey for a response rate of 33%. The state of quality improvement maturity was scored as *Progressing*, defined by having some quality improvement experience but lack of commitment and minimal quality improvement integration. Public Health is striving to move up the levels of maturity during the 2024–2028 reporting term.

The Quality Improvement Maturity Tool is a validated survey that is used to assess the state of quality improvement in public health units in Ontario. The tool was developed and used in the

United States and was subsequently validated and modified for Ontario's use by Law et al. (Brock University).

4.3 Number of cross-training opportunities available for staff in key emergency response roles that facilitate staff rotation, staff respite, and staff redeployment for surge response

In 2025, eight opportunities were available for staff in key emergency response roles that facilitate staff rotation, staff respite, and staff deployment for surge response. Examples include training for case and contact management, training on administration of immunizations, and cross-training for key administrative processes to support coverage.

Alignment with the 2026-2028 Risk Management Plan

The following risks from the 2026-2028 Risk Management Plan align with the findings from the measures for strategic priority 4, Heathy and resilient workforce, illustrating potential risks to continued achievement of this strategic priority:

3.1: Inability to staff programs and support services with enough employees, talent, and institutional history due to retention and recruitment challenges resulting from (a) stiff competition from external opportunities, and (b) hybrid work which requires on-site work limiting flexibility for employee, while also allowing off-site work that can increase disengagement, decreased connection, and diminished collaboration.

3.2: Decreased staff engagement, productivity, and well-being due to staff experiencing change fatigue from ongoing organizational changes, as well as compounding personal and professional challenges.

Conclusion

The results presented in the 2025 Accountability Monitoring Report illustrate continued progress on Public Health's requirements, with a particular focus on the operationalization of the agency's Strategic Plan.

Given that this was the first fulsome year of data collection and reporting for the 2024–2028 term, some strategic priority performance measures are reported as N/A for 2024 due to no longer being comparable to the submissions and data in 2025. This is due to the development of new criteria that places a stronger emphasis on demonstrating the outcome and impact of each initiative or activity. This ensured that submissions reflect not just what was done, but the meaningful results achieved.

Further, it is noted that Ministry of Health compliance with organizational requirements is reported one year earlier than the reporting period of this report; that is, compliance in 2024 is reported in 2025, and compliance in 2025 will be reported in the 2026 Accountability Monitoring Report. The reason for this delay is due to the Ministry reporting timelines, which are after this report is published. An update about the agency's 2025 compliance status will be provided by the Acting Medical Officer of Health through Board of Health reporting in 2026.

The risks outlined in the 2026–2028 Risk Management Plan support the strategic priority performance measures by identifying and mitigating organizational and system-level barriers that could affect progress in achieving the strategic and organizational priorities. Investing in controls that have yet to be funded would help further advance progress on the performance measures, thereby promoting organizational practices that also improve measurable outcomes. Future reporting in the Accountabiliy Monitoring Report will strengthen the connection between the agency risks and the strategic priority performance measures.

Overall, Public Health Sudbury & Districts remains committed to monitoring and reporting on key requirements to demonstrate the agency's accountability and transparency to both the Ministry of Health and members of local communities.

Appendix A: Data by performance measure

Strategic Priority 1: Equal opportunities for health

Performance measure	2025
1.1 Number of advocacy initiatives that support an increased understanding of health equity	1. Community Drug Strategy for the City of Greater Sudbury
1.2 Number of programs and services for which equity and diversity was improved as a result of the use of health equity assessments	1. Preventive dental care and dental screening for children in Sudbury East, Mindemoya and Espanola
1.3 Number of initiatives where the voices or perspectives of equity-deserving populations informed the development or delivery of activities that are Public Health-led or led in partnership	1. Harvest Pride – intergenerational community meals for 2SLGTBQ+ community 2. Age-friendly community committees (various) 3. Sex Workers Advisory Network of Sudbury (SWANS) 4. Planet Youth's Icelandic Prevention Model 5. Rural Community Engagement 6. Community of Practice meetings delivered with partners including Retirement Homes Regulatory Authority (RHRA), Public Health Ontario (PHO), Ministry of Labour, Immigration, Training and Skills Development of Ontario (MLITSD), and IPAC North Eastern Ontario Chapter. 7. Community Drug Strategy – City of Greater Sudbury Committee 8. Community Drug Strategy – Manitoulin 9. Community Drug Strategy – Chapleau
1.4. Qualitative description of activities that support advocacy and partnerships to improve self-determined Indigenous health	1. Indigenous Public Health meeting with community partners from Brunswick House First Nation and Chapleau Cree First Nation, with community following up to request supports in sexual health promotion. 2. Collaboration with Kina Gbezhgomi Child and Family Services (KGCFS) to review and revise an existing Joint Protocol for the Provision of Child Protection Services. 3. NOSM University Dietetic Practicum Program: Indigenous Food Sovereignty Project 4. The Indigenous Public Health team presented to the Board of Health for Public Health Sudbury & Districts in May, June, September, and November to support their learning on self-determined Indigenous health. 5. Public Health partnered with Wahnapitae First Nation and Indigenous Services Canada 6. Attendance at Chiefs of Ontario 2025 First Nations Community Wellness Conference

Performance measure	2025
	7. Establishment of the Board of Health Reconciliation Subcommittee 8. Launch of a public version of the *Unlearning & Undoing White Supremacy and Racism Project* (Unlearning Project) 9. Drop-in sessions held for First Nations in response to the measles outbreak 10. Support to Chapleau Cree Health Centre's Indigenous-led harm reduction efforts 11. Anonymous testing at Ontario Aboriginal HIV/AIDS strategy locations 12. Northern Fruit and Vegetable Program is partnering with Wiikwemkoong Unceded Territory to co-create an evaluation tool that measures the program's impact 13. Oral Health team and First Nation oral health daycare program 14. IPAC Hub engaged congregate settings located within First Nation communities

Strategic Priority 2: Impactful relationships

Performance measure	2025
2.1 Number of changes made to programs and services that improve the health of the community as a result of working collaboratively with community partners	1. Quarterly meetings with Health Sciences North and Children's Aid Society 2. Diseases of public health significance follow-ups, including case and contact management 3. The Good Food Market Program 4. Northern Fruit and Vegetable Program

Performance measure	2025
2.2 Number of partnerships, collaborations, and engagements with Indigenous-led organizations or First Nations that led to joint planning, implementation, and evaluation of programs and services for the Indigenous population	1. Wahnapitae First Nation: Diseases of public health signifance follow-up 2. Shkagamik-Kwe Health Center: Planet Youth's Icelandic Prevention Model 3. Maamwesying Ontario Health Team: Memorandum of Understanding signed 4. Atikameksheng Anishnawbek, Aundeck Omni Kaning First Nation, Baldwin Fire Department , Brunswick House First Nation, Enaahtig Healing Lodge, Gwekwaadziwin_Miikan, Kina Gbezhgomi Child and Family Services, M'Chigeeng First Nation Health Services, Mnaamodzawin Health Services Incorporated, Naandwe Miikaan (Wikwemikong) Health Centre, Naandwechige-Gamig , Noojmowin-Teg Health Centre, Norman Recollet Health Centre-Wahnapitae First Nation, Ontario Aboriginal HIV AIDS Strategy – Sudbury, Sheguiandah First Nation, Shkagamik-Kwe Health Centre, UCCM Anishnabek Police, Whitefish River First Nation, Wiidookaage Waadandan Inc., Wikwemikong Tribal Police Service: Ontario Naloxone Program 5. Wahnapitae First Nation: Inquiry and consultation regarding healthy eating programming support 6. Naandwe Miikaan (Wikwemikong) Health Centre: Training on dental health 7. Shkagamik-Kwe Health Centre: Back to school oral health screenings 8. Biidaaban Kinoomaagegamik elementary school in Sagamok: Planning for dental screening clinics 9. M'Chigeeng First Nation daycare: Dental screening clinics

2.3 Number of collaborations with municipalities that impact the health of the community	**City of Greater Sudbury**: 1. Energy Court Governance Group 2. Community Drug Strategy 3. Greater Sudbury Emergency Management Advisory Panel 4. City Greater Sudbury Special Event Advisory Team 5. Homelessness Sector Check in 6. Adverse air quality response plan 7. Participation in a tabletop exercise to model the Violence Threat Risk Assessment process and to activate a community-wide Traumatic Event System response 8. Measles preparedness 9. Emergency Planning Review 10. Community Safety and Well-Being Circle 11. Cultural safety 12. City of Greater Community Drug Strategy Executive Committee 13. Sudbury Local Immigration Partnership Council 14. Collaboration in event planning 15. Age Friendly Community Panel 16. Active Sudbury 17. Sudbury Road Safety Committee 18. Planet Youth's Icelandic Prevention Model **Killarney**: 19. Annual emergency management meeting 20. Good Food Markets 21. Stronger Together Team **Township of Baldwin:** 22. Annual emergency management meeting **Espanola:** 23. Annual emergency management meeting 24. Espanola Age-Friendly Action Plan 25. Espanola Culture and Recreation Advisory committee **Township of Sables-Spanish Rivers:** 26. Annual emergency management meeting 27. Sables-Spanish Rivers Age-Friendly Community Planning Commttee **Assiginack Township:** 28. Annual emergency management meeting **Township of Nairn and Hyman:** 29. Annual emergency management meeting **Municipality of French River:** 30. Good Food Markets 31. French River senior age-friendly committee **Municipality of St. Charles:** 32. St. Charles age-friendly committee **Municipality of Central Manitoulin:** 33. Central Manitoulin Trail Committee **Town of Northeastern Manitoulin and the Islands (NEMI), Municipality of Central Manitoulin, Town of Gore Bay:** 34. Manitoulin Partners for Water Safety

Performance measure	2025
	35. Annual emergency management meeting
2.4 Qualitative narratives or examples of programs or services, delivered in partnership, where activities have moved along the spectrum of engagement	1. Our Children Our Future (OCOF) 2. Thriving African Families 3. Afro Women and Youth Foundation 4. Sudbury Local Immigration Partnership Council (member agencies) 5. City of Greater Sudbury, Emergency Management Division 6. Greater Sudbury Public Libraries 7. Wiidookaage Waadandan Inc. 8. Manitoulin-Sudbury District Service Board 9. The ParkSide Centre 10. Community Drug Strategy – City of Greater Sudbury 11.Community Drug Strategy – Town of Northeastern Manitoulin and the Islands 12. Community Drug Strategy – Chapleau 13. Community Drug Strategy – Sudbury East 14. Community Drug Strategy – Lacloche Foothills 15. Rural community 16. Centre de santé communautaire du Grand Sudbury

Strategic Priority 3: Excellence in public health practice

Performance measure	2025
3.1 Number of improvements made that enhanced client, community, and partner experience as a result of client feedback	1. New audio technology was installed in the Boardroom to enhance sound quality and improve the experience of hybrid Board of Health meetings. 2. Feedback received from childcare supervisors resulted in a more streamlined approach to data collection when uploading information to support Child Care and Early Years Act assessments.

Performance measure	2025
3.2 Number of evidence generating projects where findings result in a change in public health practice	1. Infant Feeding Clinic evaluation 2. Measuring What Matters: A collaborative approach to chronic disease prevention program outcome measurement in Ontario (CDP LDCP project) 3. Self-assessment of evidence-informed decision-making skills among Public Health staff 4. Client Service Standards Review 5. Volunteer Resources Program Review 6. Hedgehog Data Analysis – Inspection Risk Ratings Over Time 7. Healthy Public Policy Research Project 8. Building Bridges: A community dialogue on public health access and equity for Black communities 9. Disinterment Evidence Rapid Review 10. Phase 2 LEAN Review: Early Drug Warning System 11. Watch for Us! Community sign program District Office 12. Library equipment lending 13. Environmental Scan of EDIA Policies in sports 14. Indigenous Food Sovereignty and Dietetics: A Review of Available Training Tools and Learning Opportunities for Dietitians and Dietetic Learners 15. Preparation for Parenting class evaluation 16. Food Insecurity and Food Affordability in Ontario Report
3.3 Number of upstream health promotion initiatives planned and implemented that have a higher population level or long-lasting impact	1. Review of the food safety course for Northern Ontario School of Medicine University 2. Mapping of structural stigma organizational assessment next steps 3. Monitoring food affordability 4. Emergency food plan networking and relationship building 5. Planet Youth's Icelandic Prevention Model 6. First Nation & Urban Indigenous Engagement Subcommittee

Strategic Priority 4: Healthy and resilient workforce

Performance Measure	2025
4.1a) Number of training and professional development sessions where at least 80% of survey respondents reported an increase of knowledge, skills, abilities, or competence	1. Leadership-specific training: Something Orange – HR issues in primary care: Employment law review 2. Learning module: Engagement, governance, access and protection (EGAP) principles in collecting health data 3. Leadership-specific training: Brivia core communications part 2 4. Leadership-specific training: Something Orange – Ethics Frameworks for Decision Making 5. Leadership-specific training: Something Orange – Immigration and Health 6. Evaluation: Cultivate and Connect: Staff Day 2025 7. Leadership-specific training: Something Orange – Employment law 8. Leadership-specific training: Building resiliensce through distruption 9. Evidence-informed decision making: Focus on evidence synthesis
4.1b) Number of professional development opportunities that resulted in Indigenous focused content incorporated into programs and services	1. Unlearning & Undoing White Supremacy and Racism Project 2. Abbreviated presentations to the Board of Health for Foundational Obligations to Indigenous Peoples series.
4.2 Assessment of quality improvement maturity	Progressing: 5.2

Performance Measure	2025
4.3 Number of cross training opportunities available for staff in key emergency response roles that facilitate staff rotation, staff respite, and staff redeployment for surge response	1. Support staff cross trained on key administrative processes 2. Support staff trained in high-level administrative functions and terminology used in the Communicable and Infectious Disease program 3. Support staff trained to support both Needle Syringe Program and Sexual Health Clinic programs and services 4. Support staff trained to support intake functions 5. Training provided to support staff during peak times 6. Training provided on the administration of intramuscular immune globulin 7. Measles training provided for all on call staff 8. Cross-training of all Communicable Infectious Diseases public health nurses on diseases of public health significance and tuberculosis case and contact management

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M.M. Hirji, Medical Officer of Health/Chief Executive Officer

Date: February 12, 2026

Re: Recommended Refresh to the Format of the MOH Report to the Board

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:

At every Board of Health meeting, members receive a lengthy and highly detailed Medical Officer of Health Report to the Board of Health within the consent agenda. The purpose of this report is to ensure Board members are informed of the Agency's work, and that the Agency remains accountable to the Board. This report requires significant staff time to prepare: approximately 64 person-hours on average per report. Each report therefore costs approximately $3,500 in staff time to produce per meeting, or $28,000 per year across all Board of Health meetings.

As the Agency struggles with provincial government funding that continues to be less than inflation, municipal levies have contributed more than their fair share to Public Health. The Board of Health has directed staff to find ways to limit the ongoing burden on municipal levy payers. Efforts are therefore ongoing to carefully review every process and service and identify opportunities to curtail less valuable expenditures in order to minimize budget growth while maximizing impact. As part of this effort, the Medical Officer of Heath Report has been identified as one expenditure to curtail. This reflects both the high price tag of producing the report, as well as that cost being in service of only 13 individuals—the Board of Health members.

As the organization shifts toward a more strategic orientation, a streamlined and more strategic governance Report to the Board is recommended. A proposed new reporting approach would replace the existing narrative-heavy format and copious operational statistics, with a strategic, high-level written report focused on key priorities, strategic indicators, successes, and system-level considerations. A public-facing online Indicators Report, updated monthly, would also be created to present key program and performance data.

This approach aligns with recent internal discussions on modernizing Board reporting and ensuring information remains at an appropriate governance level.

Recommended Action:

That the Board of Health approve the recommended approach for a revised format for the Medical Officer of Health Report to the Board, replacing the legacy format. The revised format, which would take effect in April 2026, would consist of the following:

1. A concise, strategic Medical Officer of Health Report to the Board delivered at each Board meeting, emphasizing major achievements, risks, trends, and organizational priorities.
2. A monthly online Indicators Report hosted on the agency website, including key program and performance data.

Alternative Action:

The Board of Health endorse continuation of the current format for the Medical Officer of Health Report to the Board of Health.

Background:

The current Medical Officer of Health report to the Board of Health has evolved over time into a detailed operational update that is resource-intensive to produce. This is due to numerous manual processes to count and track individual data elements.

The detailed and granular focus of the current report is incongruous with the Board of Health's role of strategic governance. There is an opportunity to shift to a more strategic report that better aligns with the Board of Health's governance mandate, allows for more prudent use of taxpayer resources, and continues to provide transparency to the Board of Health and to the communities we serve.

<u>High-Level, Strategic Reporting</u>

Internal consultations and preliminary considerations highlight the value of a governance-focused narrative that

- Highlights strategic priorities, system impacts, and key successes;
- Reflects significant deviations, trends, or issues requiring Board oversight;
- Demonstrates alignment with the agency's 2024–2028 Strategic Priorities and our agency's medium-term operational priorities.

<u>Indicators Report</u>

It is proposed that a public facing Indicators Report be posted on our website to enhance transparency and updated monthly. The indicators report would include data on items such as

- Compliance indicators
- Health promotion program activity measures
- Health protection and vaccine-preventable disease metrics

Efficiency and Sustainability

The goal is to automate the collection and reporting of these data elements in the Indicators Report. This will not be possible immediately, but over time as it is achieved, it will serve to minimize and ultimately eliminate staff time devoted to this work, allowing staff to redirect their talents to providing service to community members. While initial setup will require investment of time and effort, long-term savings are expected.

Next steps

If supported by the Board of Health, staff will finalize the proposed format and list of indicators to be included in the report. Internal processes will be developed to support the implementation of the revised reporting for the April 2026 Board of Health meeting.

Financial Implications:
It is anticipated that approximately $20,000 per year in staff time can be saved from the proposed refresh of the Board of Health report.

Ontario Public Health Standard:
The proposed new Ontario Public Health Standards evolve the expectations on Board of Health to be more focused on ensuring higher level outcomes, and less on processes. The proposed recommendation aligns with this direction, shifting reporting to the Board of Health towards strategic considerations and outcomes, and away from focus on day-to-day operations of individual programs.

Strategic Priority:
This recommendation aligns with the Strategic Priority of Excellence in Public Health Practice through its focus on improving accountability alongside more efficient use of taxpayer dollars.

Author:
Renée St Onge, Director, Knowledge & Strategic Services

Ministry of the Solicitor General

Office of the Chief Coroner
Ontario Forensic Pathology Service

Forensic Services and
Coroners' Complex
25 Morton Shulman Avenue
Toronto ON M3M 0B1

Telephone: (416) 314-4000
Facsimile: (416) 314-4030

Ministère du Solliciteur général

Bureau du coroner en chef
Service de médecine légale de l'Ontario

Complexe des sciences judiciaires
et du coroner
25, Avenue Morton Shulman
Toronto ON M3M 0B1

Téléphone: (416) 314-4040
Télécopieur: (416) 314-4060

January 23, 2025

Via email to each board of health

Office of Chief Medical Officer of Health, Public Health
BOARDS OF HEALTH
Ministry of Health | Ontario Public Service
777 Bay Street, 5th Floor
Toronto, Ontario M5G 2C8

Dear Boards of Health:

Re:	**Inquest into the death of:**	**Luke MOORE, died November 19, 2021** **Lorraine SHAGANASH, died November 20, 2021** **Lizzie SUTHERLAND, died November 21, 2021** **Mark FERRIS, died November 30, 2021** **Douglas TAYLOR, January 23, 2022**
	OCC Inquest File No.:	**Q2025-31**
	Date Inquest Jury Verdict & Recommendations Received:	**November 19, 2025**

The jury in the inquest into the death of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor has made recommendations which your organization may be in a position to implement. Please report back regarding your consideration to implement the recommendations relating to your organization by completing the attached chart, ***Responses to Jury Recommendations***. Responses to inquest recommendations will be made public. Therefore, your response should not contain personal identifiers with the exception of identifying the decedent.

We do request a response by **July 23, 2026,** however, the *Coroners Act* provides no authority for us to demand a response to a recommendation or set deadlines for a response. We do post responses publicly, and scrutiny of the responses has been growing. Public criticism may follow if a thoughtful response is not received in a timely manner.

A list of organizations requested to report back is provided.

We are pleased to provide you with a copy of the inquest jury verdict and recommendations. The presiding officer's verdict explanation will be sent when it becomes available.

I would like to explain the significance of inquests and consequent recommendations under the *Coroners Act*. An inquest is a public hearing conducted by a coroner (or a judge, or a retired judge or a lawyer) before a jury of five community members. Inquests are held for the purpose of informing the public about the circumstances of a death. An inquest does not find fault, blame or legal wrongdoing but rather examines the circumstances of one or more deaths and looks for lessons that can be learned from the death(s) that may contribute to a safer future for the living. Juries often make recommendations based on these learned lessons and, while they are not binding, it is hoped that implemented recommendations will prevent future deaths in similar circumstances.

Please provide us with the name and contact information of the individual leading your organization's response. If you feel any of the recommendations should be directed elsewhere, complete the attached ***Contact Information and Recommendation Referrals*** **form and forward** to occ.inquests.registraroffice@ontario.ca .

As noted above, inquest jury recommendations are not legally binding; however, we trust they will be given careful consideration for implementation and, if not implemented, that your organization provides an explanation.

Thank you for participating in this important process. Please contact me if you have any questions.

Sincerely,

David A. Cameron, MD, LLB, CCFP
Regional Supervising Coroner – Inquests

/eg

Attachments:
Responses to Jury Recommendations
List of Organizations Requested to Respond to Jury Recommendations
Contact Information and Recommendation Referrals

Responses to Jury Recommendations
BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

RECOMMENDATION #:
27 – 28, 33, 48, 52

REC. #	ORGANIZATION'S RESPONSE

List of Organizations Requested to Respond to Jury Recommendations

BLASTOMYCOSIS Inquest Q2025-31

Hopital Notre-Dame Hospital

Ornge

Public Health Ontario (PHO)

The Ministry of Health

Northeastern Public Health (NEPH)

Indigenous Services Canada (ISC)

Constance Lake First Nation (CLFN)

Jane Mattinas Health Centre (JMHC)

Chief Counsel of Constance Lake First Nation

Ontario Health

Matawa First Nations Management Health Cooperative (MFNM)

Nishnawbe Aski Nation (NAN)

Ontario Telemedicine Network (OTN)

Boards of Health

Four Rivers Environmental Services Group (Four Rivers)

Canadian Institute of Health Research CIHR)

Ministry of Colleges, Universities, Research Excellence and Security

Ministry of Agriculture, Food and Agribusiness

Ontario Ministry of Agriculture, Food, and Rural Affairs (OMAFRA)
Office of the Chief Veterinary

College of Veterinarians of Ontario
Town of Hearst

Ministry of Natural Resources

Government of Ontario

Contact Information and Recommendation Referrals
Responses to Jury Recommendations
BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

Part I: Contact Information

Name	Position Title
Email address	Telephone number

Part II: Referral

We believe the following recommendations may be best addressed by these organizations:

Recommendation Number	Organization Name & Address	Contact Name & Title

Forward to occ.inquests.registraroffice@ontario.ca

Office of the
Chief Coroner

Bureau du
coroner en chef

Verdict of Inquest Jury
Verdict du jury de l'enquête

Coroners Act - Province of Ontario
Loi sur les coroners - Province de l'Ontario

We the undersigned / Nous soussignés,

	of / de	Iroquois Falls, Ontario
	of / de	Kapuskasing, Ontario
	of / de	Iroquois Falls, Ontario
	of / de	Cochrane, Ontario
	of / de	Cochrane, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de:

Surname / Nom de famille	Given Names / Prénoms	Aged / à l'âge de
Moore	Luke	43
Shaganash	Lorraine	47
Sutherland	Lizzie	56
Ferris	Mark	67
Taylor	Douglas	60

held at / tenue à Constance Lake, and virtual via Zoom, Ontario from / du October 15, 2025 to / au November 19, 2025

By / Par Doctor Michael B. Wilson Presiding Officer for Ontario / Président de séance pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit:

Name of Deceased / Nom du défunt	Luke Moore
Date of Death / Date du décès	November 19, 2021
Place of Death / Lieu du décès	Hôpital Notre-Dame Hospital, Hearst, Ontario
Cause of Death / Cause du décès	Acute blastomycosis pneumonia
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Lorraine Shaganash
Date of Death / Date du décès	November 20, 2021
Place of Death / Lieu du décès	Health Sciences North, Sudbury, Ontario
Cause of Death / Cause du décès	Blastomycosis pneumonia complicated by acute respiratory distress syndrome and multiorgan failure
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Lizzie Sutherland
Date of Death / Date du décès	November 21, 2021
Place of Death / Lieu du décès	Hôpital Notre-Dame Hospital, Hearst, Ontario

Cause of Death / Cause du décès	Blastomyces dermatitidis, hepatitis, splenitis, and peritonitis
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Mark Ferris
Date of Death / Date du décès	November 30, 2021
Place of Death / Lieu du décès	North Bay Regional Health Centre, North Bay, Ontario
Cause of Death / Cause du décès	Multi-organ failure due to respiratory failure due to blastomycosis pneumonia
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Douglas Taylor
Date of Death / Date du décès	January 23, 2022
Place of Death / Lieu du décès	Hôpital Notre-Dame Hospital, Hearst, Ontario
Cause of Death / Cause du décès	Respiratory failure due to blastomycosis bilateral pneumonia
By What Means / Circonstances du décès	Natural

Original signed* by Foreperson /
Original signé* par le contremaître

**In-Person Inquests Only / Enquêtes en personne uniquement*

The verdict was received on / Ce verdict a été reçu le November 19, 2025

Original signed* by jurors / Original signé* par les jurés

Doctor Michael B. Wilson

Presiding Officer's Name (Please print) /
Nom du président (en lettres moulées)

November 19, 2025

Date Signed / Date de la signature

Signature / Signature

We, the jury, wish to make the following recommendations: (see following page)
Nous, membres du jury, formulons les recommandations suivantes : (voir page suivante)

Office of the Chief Coroner

Bureau du coroner en chef

Verdict of Inquest Jury
Verdict du jury de l'enquête

Coroners Act - Province of Ontario
Loi sur les coroners - Province de l'Ontario

Inquest into the death(s) of:
L'enquête sur le décès de:

	Name of Deceased / Nom du défunt
	Moore, Luke
	Shaganash, Lorraine
	Sutherland, Lizzie
	Ferris, Mark
	Taylor, Douglas

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

INQUEST INTO THE DEATHS OF LUKE MOORE, LORRAINE SHAGANASH, LIZZIE SUTHERLAND, MARK FERRIS, AND DOUGLAS TAYLOR

Reconciliation and relationship building between Constance Lake First Nation, health care institutions, and public health organizations

1. Hôpital Notre-Dame Hospital ("NDH"), Ornge, Public Health Ontario ("PHO"), the Ministry of Health, Northeastern Public Health ("NEPH"), and Indigenous Services Canada ("ISC") should commit to Joyce's Principle, which aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health, including the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health.

2. NDH will collaborate with Constance Lake First Nation ("CLFN") to determine how NDH's commitment to following and implementing Joyce's Principle will be displayed and expressed to NDH patients, visitors, staff, volunteers, service providers, and anyone else entering the hospital (e.g., posters, signage).

3. ISC and the Ministry of Health in collaboration with and under the lead of CLFN Chief and Council and the Jane Mattinas Health Centre ("JMHC") will ensure that the funding and infrastructure available to CLFN, ensures the delivery of healthcare services that meet the needs of members of CLFN.

4. NDH, Ornge, PHO, and NEPH should create and publish on their websites, within six months of this verdict, a plan to implement the Truth and Reconciliation Commission ("TRC") Calls to Action 22 and 23 as applicable.

5. The Ministry of Health should create and publish on their websites, within six months of this verdict, a plan to implement the TRC Calls to Action 18, 22, and 23.

6. ISC should continue publishing initiatives and developments to implement the TRC Calls to Action 18 to 23.

7. NDH should collaborate with CLFN community members, Chief and Council and JMHC to prepare within three months of this verdict, an updated First Nations, Inuit, Métis and Urban Indigenous Health Workplan, that was prepared as required by the NDH Hospital Service Accountability Agreement for 2024-25 with Ontario Health. The updated Health Workplan will include concrete strategies to improve outcomes for CLFN members, and creating culturally safe access to health care services, programs to foster Indigenous engagement, and relationship building to improve Indigenous health. A copy of the Workplan will be provided to CLFN community, Chief and Council and the JMHC.

8. NDH, Ornge, PHO, NEPH, and ISC will, to the extent that it is not already being provided, ensure applicable personnel are receiving Indigenous Cultural Safety Training and training on trauma-informed care within 12 months of this verdict.
a) This training will include but not be limited to board members, senior leadership and management staff, health care providers, and allied health professionals. Frontline staff should have priority when implementing this training.
b) This training will include teaching on the history and culture of the First Nations and Indigenous communities to whom these agencies provide services and the contemporary experiences of those communities in the health care system, and cover topics such as anti-Indigenous racism, managing implicit bias, understanding how emotional prejudice impacts decision making, and mitigating the harmful impact of stereotyping on health outcomes.
c) This training should be mandatory and opportunities for ongoing learning on these topics should be provided on an annual basis or more frequently.

9. With respect to Indigenous Cultural Safety Training, NDH will:
a) Collaborate with CLFN and JMHC so that members of CLFN can be involved in the planning and delivery of Indigenous Cultural Safety Training and trauma-informed health care training.
b) In recognition that cultural safety is a core clinical skill, take steps to explore that the completion of this training be a condition for credentialing of locum physicians working at the hospital. This should include consulting with the Ministry of

Health about the requirements for physicians involved in the Emergency Department Locum Program ("EDLP"). NDH to provide updates about steps taken to explore adding Indigenous Cultural Safety Training as a condition for credentialing of locum physicians to the Blastomycosis Inquest Implementation Committee.

10. The Ministry of Health and/or Ontario Health should consider ways to support health care providers and public health professionals, including physicians, nurses, and allied health professionals working in northern and remote regions of Ontario, being able to take Indigenous Cultural Safety Training and trauma-informed health care training, including by providing additional funding.

11. The Ministry of Health should consider requiring all health regulatory colleges to make Indigenous Cultural Safety Training a mandatory requirement for all regulated health professionals. This training should incorporate teachings on a "two-eyed seeing approach" to health care that incorporates both Western and Indigenous ways of knowing and conceptions of well-being.

12. The JMHC, with the support and assistance of the Matawa First Nations Management ("MFNM") Health Cooperative and ISC where requested, should request and secure funding to employ two full-time Indigenous Patient Navigators.

13. NDH to allocate and maintain funding for at least one Indigenous Patient Navigator who will work at NDH. This position should be filled by a person who is Indigenous and has knowledge of and/or connections to the history and culture of CLFN. The job description and responsibilities for the Indigenous Patient Navigator role at NDH will be co-developed with CLFN Chief and Council or JMHC (as determined by CLFN).

14. NDH should make an existing multipurpose room at the hospital a traditional healing room for Indigenous patients and families. The space will be designed to facilitate the use of Indigenous medicines, including smudging, and accessing support from Elders and Traditional Indigenous Healers. The space should be designed with the CLFN community and be dedicated to the memory of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor.

15. NDH to create a policy stating that smudging is permitted at NDH and how requests to smudge are to be facilitated. The policy will be communicated to all staff, including part-time and contract staff (e.g., locum physicians and agency nurses), and to patients. To communicate this policy to patients, NDH to post clear signs in English, French, Cree, Ojibwe and Oji-Cree stating that smudging is permitted at NDH. This should be clearly stated on NDH's website as well. Posters will also be provided to the JMHC.

16. NDH should collaborate with CLFN to explore the potential availability of having a tipi and sacred fire on the grounds of the hospital and ways to incorporate traditional teachings at the site.

17. NDH and CLFN should explore more avenues for communication and relationship-building, including regular meetings and circles. A collaborative approach will be taken to determine Terms of Reference for meetings (if any), who will participate, frequency and location of meetings, and whether minutes will be kept. Informal opportunities for relationship building will also be explored.

18. NDH should take steps to share information with CLFN members about the emergency room triage system. The information to be shared and the ways it can be shared will be developed in partnership with the JMHC.

Emergency preparedness and response in Northern Ontario and First Nations communities

19. The Ministry of Health and/or Ontario Health should develop a Northern Ontario Emergency Response Team comprised of health care professionals and public health professionals who can provide surge capacity to northern and remote communities in Ontario during public health emergencies. The development of this team should include strategies to recruit Indigenous health care professionals to serve on the Emergency Response Team.

20.The Ministry of Health and/or Ontario Health should hold a debrief after any complex multi-jurisdictional outbreak of a disease of public health significance involving a First Nations or Indigenous community. This debrief should be held within six months of the outbreak being declared over and should include all local, provincial, and federal health institutions and agencies involved in the outbreak response. The First Nations community should be invited to participate and included in the planning and facilitation of the debrief.

21. NDH to continue to offer debriefing and provide mental health support services to all NDH staff, including those under contract i.e. locum physicians, agency nurses.

22. In appropriate circumstances, regarding the death of a patient, NDH will take steps to facilitate a debrief among individuals at NDH and other organizations involved in the clinical care of the deceased. The purpose of the debrief is to have an opportunity to discuss and identify any potential lessons learned.

23. NDH to review and update training provided to frontline health care providers to ensure that any health care providers who may be required to care for critical care patients can provide the best care possible if the patient cannot be transferred to a hospital with a higher level of care. This should include taking steps to arrange, wherever possible, for nurses employed by NDH to be registered for the C3 Concepts in Critical Care simulation course offered by Health Sciences North within one year of this verdict. The Ministry of Health should provide funding to NDH to permit such training.

24. The Ministry of Health should create an inventory of public health programs and services available to First Nation communities and compare the inventory to the Ontario Public Health Standards with the goal of identifying and improving access to public health services for First Nation community members. The Ministry of Health to share this inventory with ISC, and any applicable Tribal Council in relation to transferred communities.

25. CLFN, JMHC, and the MFNM Health Cooperative to inquire if there is an emergency response and evacuation plan in place for CLFN. If there is not, they should create such a plan in consultation with Nishnawbe Aski Nation ("NAN") and request that ISC provide any necessary support or assistance, if eligible, to develop an emergency response and evacuation plan.

26. CLFN, JMHC, and Matawa Tribal Council to consider applying for funding for the planning or training on emergency

preparedness and response, under ISC's Non-Structural Mitigation and Preparedness funding of the Emergency Management Assistance Program.

27. The Ministry of Health, local Boards of Health, and ISC to explore opportunities for relationship building among public health units and ISC, with a focus on responding to future public health emergencies in First Nation communities.

28. The Ministry of Health, local Boards of Health, applicable Tribal Councils, and ISC should meet to develop and establish clear roles and responsibilities, in response to future public health emergencies and outbreaks.

Indigenous representation in health care governance and institutions

29. NDH will create two permanent positions on its Board of Directors exclusively for members of CLFN, or individuals designated by CLFN. To promote and enable full CLFN participation in NDH governance, the hospital will take steps to:
a) Make amendments to its Board by-laws as necessary.
b) Change the list of qualifications on its website to remove that one of the qualifications for the CLFN Board Member is that the person be bilingual.
c) Consult with CLFN about holding some of the NDH Board meetings at Constance Lake First Nation.

30. Within two months of this verdict, the NDH Board to expand the portfolios of one or two current board members to include engagement and relationship building with CLFN. This expanded portfolio will include areas such as:
a) Engaging with CLFN Chief and Council about the implementation of the two board positions for CLFN members on the NDH Board of Directors. If agreeable to Chief and Council, this engagement may be done in part through attending and presenting on this board membership opportunity at the next possible Chief and Council meeting.
b) Support recruitment of CLFN members to the NDH Board of Directors through circulating postings for the position and engaging with community members interested in applying for the role.
c) Ensuring Chief and Council is updated about job positions at NDH to promote within their membership, attending CLFN in person to present on job opportunities, and offering support to community members interested in applying for such positions.

31. NDH and NEPH to explore ways to encourage and support Indigenous membership on their boards and advisory committees, including outreach opportunities with First Nation communities and urban Indigenous partners, coordinating with committee chairs or other people who are responsible for the appointment of members, and identifying and addressing existing or potential barriers to participation by First Nation communities.

32. NDH and CLFN to collaborate to arrange for in person community visits where youth and adults who are interested in working in hospital administration or the health care field can connect with hospital/health care professionals to learn about their work. NDH to also explore co-op placement, volunteer, and job shadowing opportunities for students from CLFN.

Information sharing between organizations responding to public health emergencies in First Nations communities

33. To support equitable, informed, and culturally respectful public health interventions and responses, the Ministry of Health should consider requiring local Boards of Health to collect race, ethnicity, and Indigenous identity data (where appropriate) for all diseases of public health significance, including blastomycosis. Data on Indigenous identity should be collected in partnership with Indigenous communities and aligned with OCAP data principles.

34. PHO, the Ministry of Health, and ISC should collaborate to establish a secure information sharing process (in alignment with OCAP data principles) among relevant public health agencies.

35. A trilateral table should be established for the First Nations Information Governance Centre. ISC and the Ministry of Health to engage in a process to explore and achieve the development of legislation, information sharing protocols, and/or a memorandum of understanding to address the collection, use, and disclosure of personal health information and personal information relating to members of First Nations communities and First Nations health data, including for research purposes, guided by OCAP principles. This process would include but not be limited to information sharing in times of a public health emergency and should include consultation with the Information and Privacy Commissioner of Ontario.

Addressing health human resource capacity in Northern Ontario

36. The Ministry of Health and/or Ontario Health should develop and implement a comprehensive strategy to ensure sustainable, full-time access to qualified health care providers and public health professionals, including physicians, nurses, and allied health professionals, in northern and remote regions of Ontario. At a minimum, the strategy will:
a) Include consultations with health care providers working in northern and remote regions of Ontario to better understand what support they need and what steps can be taken to implement these supports.
b) Prioritize placement of health care providers in facilities experiencing critical staffing shortages, including NDH.
c) Streamline recruitment processes and practices and remove administrative impediments to attract qualified candidates.
d) Provide targeted incentives (financial or otherwise) to encourage health care providers, including physicians, nurses, and allied health professionals, to work and remain in northern and remote regions of Ontario.
e) Explore ways to limit reliance on locum physicians and nursing agencies to provide health care services in northern and remote regions of Ontario.

37. The Ministry of Health and/or Ontario Health should develop and implement, in collaboration with Indigenous communities, including CLFN, a recruitment and retention strategy to attract, hire, and retain First Nations, Inuit, Métis and Urban Indigenous people pursuing careers as health care providers and/or public health professionals, particularly in northern and remote regions of Ontario.

38. To ensure continued funding and expand the availability of the Virtual Critical Care ("VCC") Program to guarantee 24/7 access to remote consultations and support, the Ministry of Health should consider the creation of a full-time, dedicated position responsible for providing VCC services.

39. The CritiCall Ontario Program to conduct an internal review to confirm removal of any administrative barriers to accessing health care, ensuring that patients can continue to access the urgent and emergent care they need as close to home as possible.

40. The Ministry of Health and/or Ontario Health should establish, allocate, and maintain funding for a dedicated nurse practitioner and/or family physician (general practitioner) position to deliver care to CLFN members on a regular basis. The Ministry of Health should consult CLFN and MFNM during the development of such a position and through the recruitment process to ensure their needs and views are considered.

41. To enhance and ensure consistent ground transportation services for CLFN members to and from health care services in Hearst and surrounding areas, including outside of weekday daytime business hours, during weekends and holidays. ISC and the Ministry of Health should consult CLFN to ensure that their specific needs are considered and addressed. Where necessary, the Ministry and ISC should seek, secure, and maintain any required additional funding to sustain these transportation services.

42. The Ministry of Health and/or Ontario Health should explore expanding the availability of virtual care services at the JMHC including through the Ontario Telemedicine Network ("OTN").

43. The Ministry of Health to work with the MFNM Health Co-operative and Northern Ontario School Medicine ("NOSM") University to provide stable funding to ensure the continuation of the Remote First Nations Stream and support its expansion into other communities such as CLFN.

Early identification, detection and treatment for blastomycosis

44. MFNM Technical Services and Four Rivers Environmental Services Group ("Four Rivers") should explore additional funding opportunities that may allow Four Rivers to continue its work related to blastomyces and blastomycosis in CLFN and other MFNM communities, including but not limited to research, ongoing environmental sampling and testing, public education, and the development of an early warning system that could integrate artificial intelligence to monitor, identify, and alert to trends in real-time.

45. For any research work related to blastomyces and blastomycosis, MFNM Technical Services and Four Rivers will work with CLFN within three months of this verdict to create a plan for:
a) Scheduling a meeting with the Canadian Institute of Health Research ("CIHR");
b) Identifying potential partnerships with Canadian universities;
c) Identifying potential Canadian professors and/or practitioners to supervise this research;
d) Establishing a sampling and research hub in CLFN; and
e) Outlining how the research will be conducted in alignment with OCAP principles.

46. MFNM and Four Rivers to explore with CLFN Chief and Council establishing a hub for blastomyces and blastomycosis research in CLFN. If such a hub is created, it should be community-led and governed.

47. Public health agencies (e.g., public health units, ISC, and First Nations health services providers such as Tribal Councils and community health centres, as applicable) should increase public education on symptoms and risk factors of blastomycosis, particularly in endemic areas. Messaging should be culturally safe, language-accessible, locally relevant, and developed in collaboration with First Nations communities (where appropriate) to incorporate local knowledge and lived experience, particularly regarding identifying potential environmental or activity-related risks.

48. To the extent that they are not already provided, PHO, the Ministry of Health, ISC, and local Boards of Health should, as appropriate to their mandates, provide education and resources to health care providers and public health professionals regarding diagnosis and treatment for blastomycosis, including, where appropriate, when to consider blastomycosis, aligned with current evidence, public health data, and clinical guidance.

49. PHO should explore acquiring access to the blastomyces urine antigen testing (a non-invasive adjunct to existing diagnostic methods for blastomycosis) in Ontario, with implementation to be led by PHO. Necessary funding should be secured and maintained by the Ministry of Health.

50. PHO should explore opportunities to increase access to clinical diagnostic methods for blastomycosis for Northern Ontario communities. Necessary funding should be secured and maintained by the Ministry of Health.

51. PHO to develop an Ontario Investigation Tool for blastomycosis to standardize information collected by public health agencies from cases of blastomycosis and support data entry and completeness in the provincial diseases of public health significance surveillance system (i.e., iPHIS). Consideration should be given to including questions specific to activities and interactions with the land reflecting the lived experience of members of First Nations communities.

52. The Ministry of Health to engage with the Ontario Ministry of Agriculture, Food and Agribusiness, and the Office of the Chief Veterinarian for Ontario and/or the Ontario Veterinary College to explore opportunities to review and analyze data on confirmed and clinical canid cases (e.g., in dogs) of blastomycosis in Ontario. Findings should be shared with PHO, local Boards of Health, ISC, and First Nation Tribal Councils as they may enable early warning for human cases.

53. NDH to incorporate education on blastomycosis in the hospital's orientation booklet for locum physicians working shifts at NDH. NDH and CLFN to collaborate in the preparation of a description of CLFN to be included in the hospital's orientation booklet for locum physicians.

54. The Ministry of Health should update the Exceptional Access Program ("EAP") to allow blastomycosis as an indication for coverage of posaconazole or isavuconazole in certain exceptional cases, where patients cannot tolerate itraconazole or voriconazole.

Transfer to higher levels of care from First Nations communities in Northern Ontario

55. The Town of Hearst should engage with CLFN, Ornge, and NDH to explore opportunities for joint advocacy for the purpose of attempting to secure public funding for the Hearst René Fontaine Municipal Airport (the "Hearst Aerodrome"), which may include funding for the following:
a) Runway improvements, such as a runway extension and/or the construction of an additional runway;
b) Upgraded runway lighting; and
c) Enhanced on-site weather observation capability at the Hearst Aerodrome.

56. The Town of Hearst to continue exploring opportunities to secure an anchor tenant (e.g., a commercial or not-for-profit enterprise) for the Hearst Aerodrome for the purpose of enhancing the likelihood of obtaining ongoing public funding for the Hearst Aerodrome. The Town of Hearst to also engage with NAN for its input on potential anchor tenants.

57.The Town of Hearst should ensure that currently available de-icing and anti-icing services remain available at the Hearst Aerodrome on request to air operators.

58. The Town of Hearst should ensure that the Hearst Aerodrome's current winter maintenance services remain available on request to medical evacuation air operators at all times.

59. The Town of Hearst should continue applying communication protocols with NDH for the purpose of promoting timely patient transfers through the Hearst Aerodrome.

60. The Town of Hearst should continue with initiatives to collect anonymized statistics from NDH regarding patient transfers from the Hearst Aerodrome for the purpose of supporting the Town of Hearst's ongoing efforts to secure public funding for the Hearst Aerodrome.

61. The Town of Hearst should engage with CLFN, NAN, Ornge, and NDH to discuss best practices regarding operations at the Hearst Aerodrome to promote safe and timely medical transfers. Engagement will commence with a meeting between these parties within 90 days of the close of the Inquest, at which meeting the parties will discuss and attempt to agree on the appropriate mode and frequency of future engagement.

62. The Ministry of Health and Ornge should collaborate with referring, transporting, and receiving health care settings on how to best provide consistent and clear messaging about triage processes and triage status of specific patients. This collaboration will include considerations for health care staff in how to communicate triage decisions to patients and their families.

63. The Ministry of Health should expedite the funding of Ornge's rotor-wing fleet expansion to enable Ornge to further enhance capacity and decrease response times in Northern Ontario, enabling better operationalization of Ontario's Life or Limb policy in Northern Ontario.

64.The Ministry of Health and Ornge should develop a mechanism for evaluating Ornge's needs for rotor-wing aircrafts on an annual basis to ensure ongoing fleet enhancements in between update cycles.

Oversight and accountability in health care delivery to members of First Nations communities

65. NDH should collaborate with CLFN and JMHC to create an accessible and trackable process for concerns/complaints, whether written or verbal, to be raised by CLFN members.

66. The Ministry of Health and Ontario Health should explore creating an Indigenous Patient Ombudsperson to receive and address health care complaints from First Nations or Indigenous patients. This office should be Indigenous-led with the goal of resolving complaints from First Nations patients arising from their experiences in Ontario's public hospitals.

Promoting holistic wellbeing for Constance Lake First Nation community members.

67. CLFN to continue providing JMHC staff with mental health and other supports when a state of emergency is in place.

68. MFNM Technical Services to work with CLFN to develop and implement a plan within six months of this verdict for ongoing biannual monitoring of the drainage ditches in CLFN, particularly on the eastern side of the community near Wilmot Lake. As part of this monitoring, drainage ditches will be maintained to ensure they remain properly graded and clear of organic materials that may create growth-promotive conditions for blastomyces. MFNM Technical Services and CLFN will continue to seek assistance from ISC, and ISC will provide support where appropriate.

69. MFNM Technical Services will work with CLFN to develop a plan for conducting comprehensive inspections of houses in CLFN for mold, and how they plan to remediate any mold found within three months of this verdict. ISC to respond to requests for assistance or support made by MFNM Technical Services and CLFN where appropriate.

70. ISC, CLFN, Matawa, Ontario's Ministry of Natural Resources, private industry partners, and any other identifiable stakeholders should:
a) Meet to identify steps that can be taken to address the growth of blue-green algae in Constance Lake;
b) Prepare a plan outlining those steps; and
c) Include in that plan a biannual inspection and review of the plan for blue-green algae remediation, within three months of this verdict.

71. Ontario's Ministry of Natural Resources and/or any responsible provincial ministry, and any private industry partners who contributed to the sawdust pile located at the entrance of the CLFN reserve, should work with CLFN to remove the sawdust pile.

72. MFNM Technical Services to provide CLFN Chief and Council reports of any inspection, investigation, and remediation of environmental health concerns in the CLFN community.

73. ISC should explore securing additional funding for the work outlined in recommendations 68-70 if funding is requested by MFNM Technical Services to implement these recommendations.

74.The Ministry of Health and ISC should explore providing sustained multi-year funding for Indigenous Health Transformation initiatives.

75. The Ministry of Health, ISC, NEPH, PHO, and CLFN should issue a formal endorsement of Indigenous health transformation as a collaborative process between ISC, the provinces and territories, and First Nations governments that supports First Nation communities' right to self-determination through the full control, design, delivery, and management of their own health services.

Implementation and reporting

76. NDH and CLFN will establish the Blastomycosis Inquest Implementation Committee to provide mutual accountability, exchange of knowledge, and to support both NDH and CLFN in implementing recommendations from this inquest.
a) The Blastomycosis Inquest Implementation Committee should include representatives of NDH executive leadership, the CLFN Chief or a Council member, the JMHC IPN(s) and, if they wish to participate, family members of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor.
b) The NDH CEO will report on the work of the Blastomycosis Inquest Implementation Committee in their monthly reports to the NDH Board.
c) The Blastomycosis Inquest Implementation Committee will provide public updates every six months, commencing May 15, 2026, on the status of implementation of each recommendation. NDH will publish the update on its website, and CLFN will publish the update on its website and the community's Facebook page.
d) NDH will explore opportunities to provide support to the Blastomycosis Inquest Implementation Committee, including access to internal resources for project management and communications.

77. Within 12 months of this verdict, NEPH, PHO and ISC will each prepare a status report on recommendations specific to public health matters addressed to them and provide a copy of this report to the Office of the Chief Coroner and to all parties with standing before the Inquest, and to NDH and CLFN to the attention of the Blastomycosis Inquest Implementation Committee.

Additional Funding

78. Province of Ontario, Government of Canada to provide funding to allow for the implementation of recommendations made in this inquest.

79. The Government of Ontario should consider establishing a legal fee reimbursement program for a First Nation to apply for certain costs of legal representation for an Inquest, in the interest of First Nation Access to Justice.

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____